Supreme Court, U.S.
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No. 99-

IN THE

Supreme Court of the United States

COUNTY OF LOS ANGELES, a political subdivision of the State of California, owner and operator of Los Angeles County/USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital, *et al.*,

Petitioners,

v.

DONNA E. SHALALA, Secretary, U.S. Department of Health and Human Services,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

This case involves certain Medicare payments to hospitals, called "outlier" payments, which are provided as supplemental payments for inpatient services provided to the sickest and costliest patients. The precise questions presented to the Court are as follows:

1. Whether 42 U.S.C. § 1395ww(d)(5)(A)(iv) unambiguously requires that the actual amount of outlier payments paid nationwide during a fiscal year not be less than 5% of the total Medicare Prospective Payment System payments for inpatient services projected or estimated to be made for that year?

2. Whether, pursuant to *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), a court should afford deference to an agency interpretation of a federal statute which is not contained in an agency regulation or adjudication?

PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

(Omitted here but printed as Appendix F, page 87a)

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County of Los Angeles, a political subdivision of the State of California, owner and operator of Los Angeles County/USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King, Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital, along with the other plaintiff hospitals in the consolidated cases (collectively, "Hospitals" or "Petitioners"), respectfully petition for a writ of certiorari to review that part of the Judgment of the United States Court of Appeals for the District of Columbia Circuit which was in favor of Respondent Donna E. Shalala, Secretary of the United States Department of Health and Human Services ("Secretary").

OPINIONS BELOW

The Opinion of the United States Court of Appeals for the District of Columbia Circuit (App. A) is reported at 192 F.3d 1005 (D.C. Cir. 1999). The denial of rehearing and rehearing *en banc* (App. D) is unreported. The Judgment of the United States District Court for the District of Columbia (App. B) is reported at 992 F. Supp. 26 (D.D.C. 1998). The subsequent Order of the District Court (App. C), dated April 30, 1998, is unreported.

STATEMENT OF JURISDICTION

The Court of Appeals entered its Judgment on October 1, 1999. (App. A). A Petition for Rehearing and Suggestion for Rehearing *En Banc* (App. D) was denied on November 30, 1999. Congress granted the Court jurisdiction over such final judgments by writ of certiorari pursuant to 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The following federal statutes are involved in this case: 42 U.S.C. § 1395ww(d)(3)(B) and 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv). A copy of these statutes is attached at App. E. The most critical part of the statutes at issue in this case is § 1395ww(d)(5)(A)(iv), which reads as follows:

> The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

STATEMENT OF THE CASE

These consolidated cases involve a challenge by 181 hospitals (the "Hospitals") to a determination by the Secretary of the United States Department of Health and Human Services (the "Secretary") concerning the amount of Medicare reimbursement due to the Hospitals for services during federal fiscal years ("FYs") 1985 and 1986. The amounts in dispute are for services provided to "outlier" patients, i.e., patients whose length of stay or cost of care are unusually high and for whom additional payments are made under Medicare's Prospective Payment System ("PPS"). The Hospitals seek additional outlier payments for FYs 1985 and 1986, because the amount of outlier payments for each year is less than the minimum amount mandated by the applicable federal statute, 42 U.S.C. § 1395ww(d)(5)(A)(iv).

Under PPS, for hospital fiscal years beginning on or after October 1, 1983, Medicare payments to hospitals for inpatient services are based on a fixed, predetermined rate for each hospital discharge. 42 U.S.C. § 1395ww(d)(1). The amount paid under PPS for a particular patient depends on the Diagnosis-Related Group ("DRG") to which the patient is assigned. 42 U.S.C. §§ 1395ww(d)(2)(G), (d)(3)(D). The Secretary established approximately 470 DRGs and assigned different weights to each DRG reflecting the relative resources required to treat patients within that DRG. *See generally Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 142 (D.C. Cir. 1986).

Congress recognized that certain cases ("outliers") may require unusually lengthy or costly hospital stays, significantly in excess of the norm for the DRG to which the patient is assigned. Given the fixed payment rates under PPS, a hospital treating many outlier cases could suffer substantial losses, notwithstanding the hospital's efforts to reduce costs.[1] To mitigate such losses, Congress required the Secretary to provide additional payments for outliers.[2]

The outlier mechanism is set forth in four clauses of the Medicare Act. 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) (the "outlier statute"). Clauses (i) and (ii) establish two classes

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1. Hospitals repeatedly expressed these concerns in testimony before Congress prior to the enactment of PPS. *See, e.g., Prospective Reimbursement for Hospitals: Hearings Before the Subcomm. on Health and Env't of the House of Representatives Comm. on Energy and Commerce*, 97th Cong., 97-183, 133-34, 147, 150-153 (1982).

2. The Secretary originally proposed a minimal discretionary approach to this issue, but Congress established a mandate which provided for significantly greater outlier protection.

of outlier patients, day outliers and cost outliers. Clause (iii) provides that the additional payments under clauses (i) and (ii) would approximate the marginal cost of care beyond the applicable outlier threshold.

The fourth clause of the outlier statute is at the center of this dispute. In the fourth clause, Congress required that outlier payments be within a specified range:

> The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. § 1395ww(d)(5)(A)(iv) ("section (d)(5)(A)(iv)"). The central issue in this case is whether section (d)(5)(A)(iv) establishes an absolute mandate that the 5% level be met each federal fiscal year and thereby requires that the Secretary make additional payments to make up the difference if outlier payments fall below the 5% level. The Secretary's regulations implementing the outlier statute do not address what would happen if the 5% minimum was not met in a particular fiscal year. In the preamble to the FY 1984 PPS Final Rule, the Secretary briefly explained that she was not obligated to make hospitals whole for any shortfalls which might occur, even though these amounts had been deducted from the standardized payments.[3] This policy has never been included in regulations.

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3. Outlier payments are funded from a percentage deduction to non-outlier PPS payments. 42 U.S.C. § 1395ww(d)(3)(B). If the 5% outlier payment minimum is not met for a federal fiscal year, the Medicare program realizes a windfall because it does not pay out the full amount of the pool funded by these deductions.

For FY 1985, the Secretary decided that outlier payments would be set to the minimum of 5% of the federal portion of the PPS payments,[4] and she based the outlier thresholds on 1981 (pre-PPS) data. *County of Los Angeles v. Shalala*, 192 F.3d 1005, 1009-10 (D.C. Cir. 1999). For FY 1986, the Secretary again decided that outlier payments should equal 5% of the federal portion. However, thresholds were based on 1984 data, eventually resulting in significantly reduced day outlier thresholds (and correspondingly higher amounts of outlier payments). This increase in outlier payments did not occur immediately, because the Secretary delayed implementation of the new thresholds until May 1, 1986, based on her interpretation of congressional enactments requiring that Medicare payment rates in effect on September 30, 1985 be frozen until May 1, 1986.

As it turned out, the actual amount of outlier payments made to hospitals was well below the 5% minimum for both FY 1985 and FY 1986. Actual outlier payments were only 3% of total PPS federal payments for FY 1985 and 4.4% of total PPS federal payments for FY 1986.[5] As a result,

4. Congress established a four year transition period under which PPS was gradually phased in. During this period, a portion of each hospital's payments was based on its costs incurred during a base year, referred to as the hospital-specific portion, and a portion was based on the fixed DRG payments, known as the "federal rate" or "federal portion." During the transition period, the hospital-specific portion decreased each year, while the federal portion increased each year. *See* 42 U.S.C. § 1395ww(d)(1)(C); *Washington Hosp. Ctr.*, 795 F.2d at 142 n.3. This case concerns only the federal portion of the PPS rate.

5. The Secretary did not actually publish data on outlier payment shortfalls for FYs 1985 and 1986 until 1992. *See* 57 Fed. (Cont'd)

hospitals nationwide were underpaid by approximately $241 million for FY 1985 and $101 million for FY 1986.

Hospitals dissatisfied with the final determination of their Medicare reimbursement may obtain hearings before the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo. The Hospitals herein filed timely appeals with the PRRB seeking additional outlier payments for FY 1985 and/or FY 1986. The PRRB accepted jurisdiction over each appeal and then granted the Hospitals' requests for expedited judicial review pursuant to 42 U.S.C. § 1395oo(f)(1), expressing no view on the merits. These cases were consolidated before the District Court.

The District Court resolved this matter on cross-motions for summary judgment. Before the District Court, the Hospitals made two principal claims. First, the Hospitals asserted that section (d)(5)(A)(iv) *required* that the total of aggregate nationwide outlier payments for a particular fiscal year must constitute between 5% and 6% of total DRG projected payments. The Hospitals argued that this statute unambiguously sets a minimum of 5% for outlier payments for each fiscal year. Second, the Hospitals claimed that the Secretary had acted in an arbitrary and capricious manner when setting outlier thresholds for FYs 1985 and 1986, because she based the outlier thresholds on outdated data.

On January 20, 1998, the District Court granted in part and denied in part the Hospitals' Motion for Summary

(Cont'd)
Reg. 23,618, 23,644 (June 4, 1992). During the course of this litigation, it was determined that the figures published in the June 1992 Federal Register were not accurate. The parties have agreed on the above-cited percentages as the best estimates available to determine the outlier shortfalls.

Judgment. The court granted the Hospitals' statutory claim, concluding that section (d)(5)(A)(iv) was not ambiguous and was susceptible to only one meaning. The court found that the statute requires the Secretary to adjust outlier payments retroactively if actual outlier payments do not reach the 5% minimum. Second, the District Court rejected the Hospitals' claim that the Secretary acted in an arbitrary and capricious manner when setting the outlier thresholds for FYs 1985 and 1986.

Upon review, the Court of Appeals reversed both of the District Court's holdings. The court reversed the judgment in favor of the Hospitals on the statutory issue, finding, unlike the District Court, that the statute in question was ambiguous. Having found ambiguity in the statute, the court, pursuant to *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984), deferred to the Secretary's construction of the statute. The court also reversed the District Court's judgment in favor of the Secretary on the outlier threshold issue. The court held that the Secretary had not adequately explained her decision to ignore early PPS data when setting the outlier thresholds for FY 1985 (and the first seven months of FY 1986) and remanded the case to the Secretary "to allow her either to recalculate the outlier thresholds for fiscal years 1985-1986 or to offer a reasonable explanation for refusing to use the 1984 data in setting outlier thresholds during those years." *County of Los Angeles*, 192 F.3d at 1023.[6]

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6. *Accord Alvarado Community Hosp. v. Shalala*, 155 F.3d 1115 (9th Cir. 1998), *op. amended*, 166 F.3d 950 (1999), in which the Court of Appeals for the Ninth Circuit held that the Secretary had acted in an arbitrary and capricious manner when setting the outlier thresholds for FYs 1985 and 1986 and, further, ordered the (Cont'd)

REASONS FOR GRANTING THE WRIT

I. THE IMPORTANCE OF THE ISSUE.

Not only do these consolidated cases themselves involve 181 hospitals and at least $11 million in Medicare reimbursement, exclusive of interest, for hospitals treating the most severely ill patients, but also there is in excess of one billion dollars at stake for hospitals around the country concerning outlier payment shortfalls. In addition to the cases before the Court, an additional 8 cases pertaining to 1985 and 1986 and involving 50 hospitals are stayed at the District Court, with at least $5 million, exclusive of interest, at issue. Further, the resolution of the Secretary's statutory obligation to ensure that outlier payments reach the minimum 5% level will have a significant impact on many subsequent fiscal years. Data published in the Federal Register indicates that outlier payments were below the statutory minimum for FYs 1991 through 1996.[7] Based on this data, underpayments

(Cont'd)
Secretary to reset the thresholds using available early PPS data and to recalculate the outlier payments for the plaintiff hospitals based on the new thresholds. Having decided the case on this issue, the Ninth Circuit did not reach the statutory issue. Since the D.C. Circuit's decision on the outlier threshold issue was in favor of the Hospitals (although not going as far as the Ninth Circuit did in terms of remedy), the Hospitals do not seek Supreme Court review regarding this issue.

7. *See* 57 Fed. Reg. 39,746, 39,783-84 (Sept. 1, 1992); 58 Fed. Reg. 46,270, 46,347 (Sept. 1, 1993); 59 Fed. Reg. 45,330, 45,408 (Sept. 1, 1994); 60 Fed. Reg. 45,778, 45,855 (Sept. 1, 1995); 61 Fed. Reg. 46,166, 46,229 (Aug. 30, 1996); 62 Fed. Reg. 45,966, 46,041 (Aug. 29, 1997). According to the most recent figures published by the Secretary for each fiscal year, the percentages paid
(Cont'd)

nationwide for FYs 1991-1996 appear to be in excess of $3 billion. The Hospitals are aware of pending administrative appeals concerning outlier payments for FYs 1991-1996 involving approximately 1200 hospitals and more than $1 billion at issue. Numerous additional appeals are probably also pending. With so much at stake, this case has, in fact, a much more far-reaching impact than other Medicare cases accepted for review by this Court in recent years. *See, e.g., Shalala v. Guernsey Mem'l Hosp.*, 514 U.S. 87 (1995); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402 (1993).

In addition to its impact on pending appeals, this Court's determination of this significant issue of statutory interpretation will have an impact on the entitlement to Medicare outlier payments of approximately 4,000 hospitals nationwide for the present and future. The adequacy of outlier payments is important to support the financial viability of hospitals treating substantial numbers of extremely ill patients and to ensure that the care for such patients is not compromised as a result of fiscal concerns. While there do not appear to have been outlier shortfalls during the period from 1997 through 1999, the language of section (d)(5)(A)(iv) remains unchanged. Judging from past experience, there is a likelihood that outlier payments will fall below the 5% level in the future, paving the way for more administrative appeals and litigation until this matter is resolved. While a denial of the petition for certiorari by this Court will leave the decision of the D.C. Circuit standing, any hospital has the option of filing a Medicare appeal in the judicial district in which it is located. Thus, if the Court does not resolve this issue now, the issue will continue to be litigated in District and Circuit Courts around the country.

(Cont'd)
in each year were: 1991 - 4.24%; 1992 - 3.6%; 1993 - 4.2%; 1994 - 3.5%; 1995 - 3.8%; 1996 - 4.2%.

In addition to the vast impact this case has on thousands of hospitals nationwide, the issues raised in the two questions presented are of significant importance beyond the specific Medicare policy involved. First, this case focuses on judicial analysis under the first prong of the analytical framework established in *Chevron* for reviewing agency interpretations of statutes. Petitioners believe that the D.C. Circuit improperly focused on identifying a statutory ambiguity which would require the issue to be decided under step two of the *Chevron* analysis, rather than making a concerted effort to determine the statute's meaning. The question whether this approach was appropriate is extremely important, as it implicates the "duty of the judicial department to say what the law is" and raises fundamental separation of powers concerns. *See Marbury v. Madison*, 1 Cranch. 137, 177 (1803).

The second issue, whether courts should give *Chevron* deference to an agency's informal interpretation of a statute, is not only the subject of direct conflict among Circuit Courts, but is also one of substantial importance. Courts are frequently called upon to review agency interpretations which are not embodied in a regulation or adjudication. The question of what level of deference should be given to such interpretations has badly divided courts around the country and is an issue engendering increasing confusion. *See* Kenneth Culp Davis & Richard J. Pierce, Jr., *Administrative Law Treatise* § 3.5 (3rd ed. Supp. 1999). Previous pronouncements by this Court have not definitely resolved this issue, which is central to administrative law decision-making. This case presents an excellent opportunity for the Court to provide much-needed guidance.

II. THE CIRCUIT COURT MISREAD THE OUTLIER STATUTE, WHICH UNAMBIGUOUSLY REQUIRES THAT ACTUAL OUTLIER PAYMENTS BE NOT LESS THAN 5% OF PROJECTED OR ESTIMATED DRG PAYMENTS.

The interpretation of section (d)(5)(A)(iv) should be resolved under step one of the *Chevron* framework. Under step one, the court determines "whether Congress has directly spoken to the precise question at issue," applying the traditional tools of statutory construction. *Chevron*, 467 U.S. at 843 n.9. Congressional intent concerning the minimum level of outlier payments to be made can readily be ascertained from the plain language of section (d)(5)(A)(iv):

> The *total amount of the additional payments* made under this subparagraph for discharges in a fiscal year *may not be less* than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

42 U.S.C. § 1395ww(d)(5)(A)(iv) (emphasis added). The District Court correctly recognized the lack of ambiguity in this statutory language.

The Circuit Court chose to ignore the clear statutory language and to search throughout other statutory provisions to find ambiguity where there is none. Citing this Court's recent decision in *Regions Hosp. v. Shalala*, 522 U.S. 448 (1998), in which the Court found that the phrase "recognized as reasonable" could refer to action already taken or to action about to be taken, the D.C. Circuit found that the word "made" (in the phrase "additional payments made") could

be read as either past or future tense. However, any perceived ambiguity in the tense of the word "made" is irrelevant to the question at hand: whether *actual* outlier payments, rather than *projected* payments, must be measured against the statutory minimum. Even interpreting "made" as meaning "to be made," the statutory language does not contain any ambiguity as to whether projected, rather than actual, outlier payments should be measured against the 5% minimum.[8]

More critical than the meaning of the word "made" is the fact that the modifier "projected or estimated" does not appear in the first part of section (d)(5)(A)(iv). Congress could easily have instructed the Secretary to use projections when referring to outlier payments at the beginning of section (d)(5)(A)(iv), simply by inserting the word "projected" in the first part of the clause. Because Congress used the phrase "projected or estimated" to modify total DRG payments, but did not use the phrase "projected or estimated" to modify total outlier payments, section (d)(5)(A)(iv) *must be* interpreted to require that actual outlier payments be compared with projected or estimated DRG payments. *See Russello v. U.S.*, 464 U.S. 16, 23 (1983); *Brown v. Gardner*, 513 U.S. 115, 120 (1994).[9] The Hospitals' interpretation of

8. In fact, "made" at the beginning of section (d)(5)(A)(iv) can be read to place no temporal gloss at all on the payments, i.e., the phrase "additional payments made under this subparagraph" seems intended simply to describe outlier payments. Thus, section (d)(5)(A)(iv) can be rewritten to provide that the "total amount of outlier payments for discharges in a fiscal year may not be less than 5 percent. . . ."

9. The only other textual support cited by the Circuit Court for its conclusion that section (d)(5)(A)(iv) is ambiguous is another provision of the Medicare Act, 42 U.S.C. § 1395ww(d)(3)(B), (Cont'd)

section (d)(5)(A)(iv) is further supported by a recent Senate Finance Committee Report published after the Circuit Court issued its decision. On October 26, 1999, the Senate Finance Committee issued its report in connection with the *Medicare, Medicaid, and S-Chip Adjustment Act of 1999*, S. 1788, 106th Cong. (1999), which includes revisions to the Medicare Act. One such revision would require the Secretary to implement an outlier payment mechanism for hospital outpatient services, much like the outlier mechanism established for inpatient services. In the context of explaining this provision, the Finance Committee commented on the shortfalls which have occurred for inpatient outliers:

> With regard to the inpatient PPS outlier policy, the Committee directs HCFA to comply with Section 1886(d)(5)(A) of the Social Security Act

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(Cont'd)
which, in requiring the Secretary to reduce standard PPS payments to fund outlier payments, calls for advance estimates of outlier payments to determine how large the reduction should be. *County of Los Angeles*, 192 F.3d at 1015. Turning logic and principles of statutory construction on their heads, the panel suggested that because Congress had already used the term "estimated" in § 1395ww(d)(3)(B), it probably believed it was not necessary to repeat the concept numerous paragraphs later in section (d)(5)(A)(iv). A much more reasonable conclusion would be that the explicit reference to an estimate in § 1395ww(d)(3)(B) demonstrates that Congress knew how to clearly require estimates when it intended to do so. Moreover, the use of estimates in § 1395ww(d)(3)(B) is for a different purpose. It is entirely reasonable for Congress to require the Secretary to establish an outlier pool through deductions from standard PPS payments fixed at the beginning of the year, while requiring that actual outlier payments at the conclusion of the year be between 5% and 6% of total projected PPS payments, so as to ensure that the entire outlier pool has been expended.

> for all prior fiscal years with respect to cost reports which have been appealed or are subject to reopening. Section 1886(d)(5)(A) requires the Secretary to pay hospitals under Medicare an additional amount for their costlier, sicklier patients and directs that actual outlier payments are to be between 5 and 6 percent of total projected DRG payments for each fiscal year. HCFA paid outliers less than the statutorily mandated 5% minimum for eight fiscal years and paid outliers at more than the 6% maximum for two years, with the underpayments totaling substantially more than the overpayments. The Committee is concerned that HCFA has failed to implement Congress' intent that not less than 5 percent but not more than 6 percent of total DRG payments in fact be paid as outlier payments.

S. Rep. No. 106-199, at 15-16 (1999). While the Circuit Court was advised of this recent confirmation of congressional intent in the petition for rehearing, it was not before the Circuit Court when the decision herein was originally rendered.

III. THERE IS A CONFLICT AMONG THE CIRCUITS REGARDING WHETHER DEFERENCE SHOULD BE GIVEN TO AN ADMINISTRATIVE AGENCY'S STATUTORY INTERPRETATION NOT FOUND IN A REGULATION OR ADJUDICATION.

After concluding that section (d)(5)(A)(iv) is ambiguous, the D.C. Circuit proceeded, under the second step of the *Chevron* analysis, to give full deference to the Secretary's

policy regarding outlier payments. The Secretary's policy, under which adjustments are never made when outlier payments fall below the 5% statutory minimum, was neither developed through adjudication nor set forth in a regulation, where it would have been subject to the full notice and comment process. The policy, without cogent explanation, has only been mentioned in various preambulatory comments in the Federal Register. Because this policy was not subject to the full APA notice and comment process, it is analogous to agency policy set forth in sub-regulations or informal instructions, i.e., interpretive rules. As discussed further below, Petitioners believe that the Circuit Court would not have reached the same result if the *Chevron* level of deference had not been given to the Secretary's interpretation.

The question as to whether *Chevron* deference should be given to agency interpretations which are not found in a regulation or adjudication is one of great conflict among the circuits (and within some circuits as well). *Chevron* itself applied to legislative rules promulgated by the Environmental Protection Agency, and it established the standard whereby, if a statute is ambiguous, a court must accept an agency's regulatory interpretation of the statute as long as it is reasonable.[10] *Chevron*, 467 U.S. at 844. This left open the question as to how a court should treat an agency's interpretive rules in similar situations, i.e., when the statute being interpreted is ambiguous.

Many courts have looked for guidance to prior Supreme Court authority to determine how much weight to give to interpretive rules. In *Skidmore v. Swift*, 323 U.S. 134 (1944),

10. *Chevron* deference clearly applies to policies adopted through agency adjudications, as well as legislative rules. *Shalala v. Guernsey Memorial Hospital*, 514 U.S. 87, 96-97 (1995).

the Court set a standard for the weight a court should give to such rules:

> We consider that the rulings, interpretations and opinions of the Administrator under this Act, while not controlling upon the courts by reason of their authority, do constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance. The weight of such a judgment in a particular case will depend upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control.

323 U.S. at 140. *See also Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977). The extent to which the *Skidmore* standard lives on after *Chevron* as an independent, less deferential standard for judicial consideration of interpretive rules is unclear.

This Court's approach has not always been consistent. In *Equal Employment Opportunity Comm'n v. Arabian American Oil Co.*, 499 U.S. 244 (1991) ("*ARAMCO*"), the Court evaluated interpretive guidelines issued by the EEOC, which had no authority to issue legislative rules or regulations. The Court followed a pre-*Chevron* case, *General Elec. Co. v. Gilbert*, 429 U.S. 125 (1976), which had used the analytical framework established by *Skidmore* when considering EEOC guidelines. The majority in *ARAMCO* does not even mention *Chevron*. In a more recent case, however, the Court has cited *Chevron* as a basis for giving "some deference" to an internal agency guideline ("akin to

an 'interpretive rule'") issued by the Bureau of Prisons and did not cite *Skidmore* or use its analytical framework. *Reno v. Koray*, 515 U.S. 50, 61 (1995).

This Court's inconsistent use of these analytical frameworks when analyzing interpretive rules has led to disarray in the manner in which the Circuit Courts have determined how much weight to give agency interpretations of statutes found in interpretive rules. As one commentator has put it, "[c]ourts are badly divided with respect to whether *Chevron* deference is due statutory interpretations announced in interpretative rules . . . . The Court should address this question definitively in order to end the rampant confusion and disagreement apparent in the circuit court opinions." K. Davis & R. Pierce, *supra*, § 3.5.

The D.C. Circuit has, in recent years, solidified its position that full *Chevron* deference should be given to interpretive rules. In *Association of Bituminous Contractors, Inc. v. Apfel*, 156 F.3d 1246, 1251-52 (D.C. Cir. 1998), the court stated, "[b]ut an agency need not promulgate a legislative rule setting forth its interpretation of a statutory term for that interpretation to be entitled to deference. . . ." The Court then deferred to the Social Security Administration's interpretation of the Coal Act, which had been explained for the first time in litigation, but which, though never expressed in a regulation, purportedly could be inferred from the agency's previous actions. Similarly, the D.C. Circuit deferred to a non-regulatory interpretation of the Medicare Act by the Secretary in *United Seniors Ass'n v. Shalala*, 182 F.3d 965, 971 (D.C. Cir. 1999), stating that such deference could be given "[e]ven if the legal briefs contained the first expression of the agency's views . . . ." *See also Tax Analysts v. I.R.S.*, 117 F.3d 607, 613 (D.C. Cir.

1997).[11] This is the same line of reasoning that the D.C. Circuit used when analyzing the policy at issue in the case before the Court, finding the Hospitals' argument "untenable" and that the Secretary's interpretation of the outlier statute was not entitled to deference because it was not adopted through either formal rulemaking or adjudication. *County of Los Angeles*, 192 F.3d at 1016.

Other circuits have followed the analytical framework adopted by the D.C. Circuit, applying *Chevron* deference to interpretive rules. The Fourth Circuit gave *Chevron* deference to the U.S. Department of Agriculture's interpretation of a statute, even though this interpretation had not been formally enacted in the form of regulations. *Warren v. N.C. Dept. of Human Resources*, 65 F.3d 385, 391 (4th Cir. 1995). The Eleventh Circuit applied *Chevron* deference to policies stated in pre-litigation opinion letters issued by the Secretary of Labor, stating clearly that, in that circuit, such policy statements are owed considerable deference. *Herman v. Nationsbank Trust Co.*, 126 F.3d 1354, 1363 (11th Cir. 1997).

On the other hand, several circuits refuse to accord full *Chevron* deference to informal agency interpretations. In *Commonwealth of Mass. v. Federal Deposit Ins. Corp.*, 102 F.3d 615 (1st Cir. 1996), the First Circuit held that the FDIC interpretation of the statutory meaning of "depositor," announced in a presentation by a staff attorney, does not warrant *Chevron* deference. "Less formal interpretations —

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11. In all these cases, the D.C. Circuit cited to *Auer v. Robbins*, 519 U.S. 452 (1997). In that case, however, this Court stated that it would defer to an agency interpretation even if that interpretation was first contained in a legal brief *only* in the context of evaluating an agency's interpretation of its own regulations, not of a Congressional enactment. *Id.* at 462-463.

policy statements, guidelines, staff instructions, and litigating positions — are not accorded full *Chevron* deference." *Id.* at 621. In *Atchison, Topeka & Santa Fe Ry. Co. v. Pena*, 44 F.3d 437 (7th Cir. 1994), the Seventh Circuit refused to give *Chevron* deference to the interpretive rules put forth by the Federal Railroad Administration, holding that the weight to be given to such rules would depend on the "'thoroughness, validity and consistency of the agency's reasoning.'" *Id.* at 442 (quoting *Orrego v. 833 West Buena Joint Venture*, 943 F.2d 730, 736 (7th Cir. 1991)). The Tenth Circuit has stated that "[m]ost circuits agree with our conclusion that *Chevron* 'deference is owed only to legislative rules and agency adjudications." *Southern Ute Tribe v. Amoco Prod. Co.*, 119 F.3d 816, 832 (10th Cir. 1997). In *Southern Ute*, the court refused to give *Chevron* deference to an opinion issued by the Solicitor of the Department of the Interior. *Id.*

Other circuits have issued inconsistent rulings on the topic, seemingly creating intra-circuit splits of authority. The Third Circuit applied *Chevron* deference to a policy stated in a letter from the HCFA Administrator to State Medicaid Directors in *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170 (3d Cir. 1995). The court stated that "[*Chevron*] deference is appropriate here even though the Secretary's interpretation is not contained in a 'legislative rule.'" *Id.* at 182, *citing Reno*, 515 U.S. at 60-61.[12] More recent opinions issued by the Third Circuit have applied what seems to be a *Skidmore* analysis, in which informal interpretations will be given deference as long as they are consistent with other agency pronouncements and further the

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12. In *Knoll*, Judge Nygaard wrote a strong, lengthy dissent, in which he argued that *Skidmore*, rather than *Chevron*, should govern the courts' analysis of interpretive rules. 61 F.3d at 190-94.

purpose of the statute. *See Cleary v. Waldman*, 167 F.3d 801, 808 (3rd Cir. 1999); *United States v. Occidental Chem. Corp.*, 200 F.3d 143, 151-52 (3rd Cir. 1999). Similarly, the Sixth Circuit has issued conflicting opinions. It has held that interpretive rules are subject to deference when they are not contrary to statute. *Your Home Visiting Nurse Servs., Inc. v. Secretary of Health & Human Servs.*, 132 F.3d 1135, 1139 (6th Cir. 1997), *aff'd*, 525 U.S. 449 (1999). On the other hand, the Sixth Circuit has withheld absolute deference to "policy statements and interpretive rulings," stating that considerable weight may only be given to such interpretations where various factors are present, including contemporaneous construction and long use. *Kelley v. E.I. DuPont De Nemours & Co.*, 17 F.3d 836, 841 (6th Cir. 1994).

The above-cited cases are a small sample of the Circuit Court opinions which have discussed this issue of administrative law when ruling on the validity of a federal agency policy. This variety of Circuit Court opinion on this important issue will lead to differing results depending on which circuit is faced with analyzing particular agency action. If the proper interpretation of the outlier statute had been decided in a circuit which applies the *Skidmore* analysis to interpretive rules, rather than giving *Chevron* deference as did the D.C. Circuit, the result of this case would have been different. The Secretary's policy refusing to assure that outlier payments met the statutory 5% minimum was announced in a preamble to the final 1984 PPS regulations, but the analysis was neither thorough nor valid. The Secretary did little more than cite to the "projected or estimated" language in section (d)(5)(A)(iv) and state that the Medicare program would not adjust DRG payments to compensate hospitals for funds that were not actually paid for outlier cases. 49 Fed. Reg. 234, 265-66 (Jan. 3, 1984). As explained

above, the "projected or estimated" language in the statute did not apply to outlier payments, but rather to total DRG payments, but the Secretary offered no analysis or explanation of why her informally-stated policy was diverging from the statutory language. While the absolute deference given under *Chevron* led the D.C. Circuit to accept the Secretary's outlier policy, the more rigorous scrutiny required under *Skidmore* would have led the court to reject the policy due to the cursory nature of the reasoning behind it.

The Hospitals believe that the better-reasoned cases apply the *Skidmore* factors to the analysis of interpretive rules. The Court should take this opportunity to clarify the extent to which *Chevron* has or has not modified the reach of *Skidmore*, so that all courts will address the review of federal agency policies under a common standard.

CONCLUSION

For the foregoing reasons, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the D.C. Circuit.

Respectfully submitted,

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APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT DATED AND DECIDED OCTOBER 1, 1999

COUNTY OF LOS ANGELES, a political subdivision of the State of California, owner and operator of Los Angeles County/USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital, et al.,

Appellees/Cross-Appellants,

v.

Donna E. SHALALA, Secretary, U.S. Department of Health and Human Services,

Appellant/Cross-Appellee.

Nos. 98-5254 — 98-5262, 98-5325 — 98-5333.

United States Court of Appeals, District of Columbia Circuit.

Argued Sept. 7, 1999.
Decided Oct. 1, 1999.

* * *

Appendix A

Appeals from the United States District Court for the District of Columbia (No. 93cv00146) (No. 93cv00147) (No. 93cv00479) (No. 93cv00692) (No. 93cv00836) (No. 93cv00837) (No. 93cv01188) (No. 93cv02069) (No. 94cv01485).

* * *

Before: WALD, SILBERMAN, and TATEL, Circuit Judges.

Opinion for the Court filed by Circuit Judge WALD.

WALD, Circuit Judge:

Brought by the owners of Medicare-provider hospitals ("Hospitals") and the Secretary of Health and Human Services ("Secretary"), these cross-appeals present two issues. First, under the Medicare statute, must the Secretary provide hospitals with retroactive reimbursements to ensure that aggregate outlier payments during any given fiscal year meet minimum statutory targets? And second, has the Secretary adequately explained why, when calculating outlier thresholds for fiscal years 1985-1986, she relied on a 1981 database instead of more contemporaneous records from 1984 Medicare discharges? Finding that Congress had spoken directly and unambiguously to the first question, the district court granted partial summary judgment to the Hospitals. With respect to the second issue, however, the court perceived nothing unreasonable in the Secretary's choice of data, and entered judgment accordingly for the Secretary. Because we disagree with the district court on both points, we now reverse.

Appendix A

I. BACKGROUND

Through a "complex statutory and regulatory regime," *Good Samaritan Hosp. v. Shalala,* 508 U.S. 402, 404, 113 S.Ct. 2151, 124 L.Ed.2d 368 (1993), the Medicare program reimburses qualifying hospitals for the services that they provide to eligible patients. *See* Social Security Act, Pub.L. No. 89-97, tit. XVIII, 79 Stat. 286, 291 (1965) (codified as amended at 42 U.S.C. §§ 1395-1395ggg (1994 & Supp. III 1997)). From its inception in 1965 until October 1983, Medicare compensated hospitals for the "reasonable costs" of the inpatient services that they furnished. *See* 42 U.S.C. § 1395f(b). Experience proved, however, that this system bred "little incentive for hospitals to keep costs down" because "[t]he more they spent, the more they were reimbursed." *Tucson Med. Ctr. v. Sullivan,* 947 F.2d 971, 974 (D.C.Cir.1991).

To stem the program's escalating costs and perceived inefficiency, Congress fundamentally overhauled the Medicare reimbursement methodology in 1983. *See* Social Security Amendments of 1983, Pub.L. No. 98-21, § 601, 97 Stat 65, 149. Since then, this new regime, known as the Prospective Payment System ("PPS"), has reimbursed qualifying hospitals at prospectively fixed rates. By establishing predetermined reimbursement rates that remain static regardless of the costs incurred by a hospital, Congress sought "to reform the financial incentives hospitals face, promoting efficiency in the provision of services by rewarding cost/effective hospital practices." H.R. REP. No. 98-25, at 132 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 351.

Appendix A

Calculating prospective-payment rates begins with determining the "federal rate," a standard nationwide cost rate based on the average operating costs of inpatient hospital services. *See* 42 U.S.C. § 1395ww(d)(2)(A)-(B); 49 Fed.Reg. 234, 251 (1984). To account for regional variations in labor costs, the Secretary then establishes a wage index that augments the adjusted standardized payment depending on the location of a qualifying hospital. § 1395ww(d)(2)(H), (d)(3)(E). The final variable is an additional weighting factor that reflects the disparate hospital resources required to treat major and minor illnesses. § 1395ww(d)(4). For each of 470 medical conditions — known as diagnosis related groups or "DRGs" — the Secretary assigns particular weights by which the federal rate is to be multiplied. The more complicated and costlier the treatment is, the greater the weight assigned to that particular DRG will be. To calculate the final "DRG prospective payment rate" for a patient discharge, the Secretary takes the federal rate, adjusts it according to the wage index, and then multiplies it by the weight assigned to the patient's DRG. By statutory mandate, the Secretary must publish the weights and values that she will factor into the prospective-payment calculus before the start of each fiscal year. § 1395ww(d)(6).

Despite the anticipated virtues of PPS, Congress recognized that health-care providers would inevitably care for some patients whose hospitalization would be extraordinarily costly or lengthy. To insulate hospitals from bearing a disproportionate share of these atypical costs, Congress authorized the Secretary to make supplemental "outlier payments." During the years at issue in these cross-appeals, the outlier-payment provisions were set forth

in four clauses of the Medicare statute. 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) (Supp. IV 1986). With the first two clauses, Congress established two classes of outlier payments: day outliers and cost outliers. § 1395ww(d)(5)(A)(i)-(ii). A hospital could qualify for a day-outlier payment if the patient's length of stay exceeded the mean length of stay for that particular DRG by a fixed number of days or standard deviations. § 1395ww(d)(5)(A)(i). Along the same lines, the Secretary would make cost-outlier payments when a hospital's cost-adjusted charges surpassed either a fixed multiple of the applicable DRG prospective-payment rate or such other fixed dollar amount that the Secretary established. § 1395ww(d)(5)(A)(ii). In the third clause, Congress provided that outlier payments "shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable" to the day or cost outlier. § 1395ww(d)(5)(A)(iii).

It is the fourth and final clause, however, that forms the textual nub of the present controversy. § 1395ww(d)(5)(A)(iv). During 1985 and 1986, paragraph (5)(A)(iv) provided:

> The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

Id. Traditionally, the Secretary has read paragraph (5)(A)(iv) to mean that at the start of each fiscal year, she must establish the fixed thresholds beyond which hospitals will qualify for outlier payments at levels likely to result in outlier payments totaling between five and six percent of projected DRG payments for that year. In making this estimation, the Secretary first settles on the per-diem outlier payment, which pursuant to § 1395ww(d)(5)(A)(iii), must approximate the marginal cost of care. She then examines historical Medicare-discharge data to determine which thresholds, when multiplied by the per-diem payment rate, would probably yield total outlier payments falling within the five-to-six-percent range in paragraph (5)(A)(iv). As the Secretary observed during the rulemaking, however, "given the data available, forecasts of probable future outlier payments are inexact." 50 Fed.Reg. 35,646, 35,710 (1985). If it turns out that the Secretary overestimated the mean length of stay for DRGs, the actual total outlier payments at the end of the year may amount to less than five percent of estimated DRG-related payments. Conversely, underestimating the mean length of stay might produce outlier payments in excess of six percent of estimated total DRG payments.

Whether the Secretary's projections prove to be correct will depend, in large part, on the predictive value of the historical data on which she bases her calculations. For fiscal year 1984, the Secretary relied on data culled from the 1981 Medicare Provider Analysis and Review ("1981 MEDPAR") file, a database containing 1.6 million Medicare discharges from 1981. As a product of the old reasonable-cost system, however, the 1981 MEDPAR file obviously did not reflect

one of "[t]he most commonly accepted expectation[s] about the PPS at the time of its inception[:] that it would result in shorter stays for Medicare patients." OFFICE OF RESEARCH & DEMONSTRATIONS, HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. 03231, REPORT TO CONGRESS: IMPACT OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM 6-13 (1984). By 1984, however, preliminary data indicated that the mean length of stay for virtually all DRGs had, as anticipated, declined dramatically under PPS. The Secretary, nevertheless, chose to rely again on the 1981 MEDPAR file in setting outlier thresholds for fiscal years 1985-1986. During those years, though the Secretary set thresholds at a level projected to result in outlier payments at or above paragraph (5)(A)(iv)'s five-percent floor, actual outlier payments in 1985 constituted only 3.0 percent of estimated DRG-related payments and in 1986 they amounted to 4.4 percent.[1] Given the enormity of the Medicare program, these seemingly modest percentage differences represent substantial sums of money: $241 million for fiscal year 1985 and $101 million for fiscal year 1986.

Because actual outlier payments for fiscal years 1985-1986 amounted to less than five percent of projected DRG-related payments, the Hospitals petitioned the Secretary for retroactive reimbursements to satisfy the difference. According to the Hospitals, paragraph (5)(A)(iv) does more than instruct the Secretary about where she should

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1. Note that these percentages were derived from the *actual* total DRG prospective payments in 1985 and 1986, not the projected payments as set forth in the statute. Both parties have agreed that this is the only practical method of calculating shortfalls at this point. *See* Br. of Sec'y at 13 & n.4; Br. of Hosps. at 4 & n.3.

set outlier thresholds at the beginning of each fiscal year; it affirmatively commands her to recalibrate retroactively the outlier thresholds if, after the fiscal year concludes, actual outlier payments do not equal at least the five-percent statutory target. Moreover, the Hospitals claimed that the Secretary had acted arbitrarily and capriciously by relying on the 1981 MEDPAR file when she forecast outlier thresholds for fiscal years 1985-1986. The Secretary rejected both claims, and the Provider Reimbursement Review Board authorized the Hospitals to seek expedited judicial review pursuant to 42 U.S.C. § 1395oo(f).

In an opinion and order dated January 20, 1998, the district court granted in part and denied in part both the Secretary's and the Hospitals' cross-motions for summary judgment. In granting a portion of the Hospitals' motion, the court proceeded no further than the first step of *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), concluding that paragraph (5)(A)(iv) unambiguously requires the Secretary to adjust outlier payments retroactively to ensure that total actual outlier payments fall within the statute's five-to-six-percent range. *County of Los Angeles v. Shalala*, 992 F.Supp. 26, 31-33 (D.D.C.1998). Holding, however, that the Secretary's decision to favor the 1981 MEDPAR file over the more recent, though preliminary, 1984 data when determining outlier thresholds was "a rational choice between two imperfect databases," the district court granted the Secretary's motion for summary judgment on the Hospitals' claim of arbitrary and capricious agency action. *Id.* at 34-36.

Appendix A

Having determined that paragraph (5)(A)(iv) required the Secretary to make retroactive outlier payments to the Hospitals, the district court instructed the parties to meet and confer on how to structure the final remedy. On April 30, 1998, based largely on a joint stipulation filed by the parties, the district court entered an order granting judgment to the parties on each of the claims on which they respectively prevailed. While the April 30 order also instructed the Secretary to tender retroactive outlier payments to the Hospitals, it did not specify a sum certain to be paid; rather, the court left it to the Secretary to calculate the amount owed. Thereafter, the Secretary noted a timely appeal and the Hospitals noted timely cross-appeals.

II. ANALYSIS

A. *Jurisdiction*

Before reaching the merits, it is necessary to examine our jurisdiction to entertain these cross-appeals. Section 1291 of the Judicial Code provides that the courts of appeals may review "all final decisions of the district courts of the United States." 28 U.S.C. § 1291 (1994). In the proceedings below, the district court, managing this case as it would any garden-variety civil suit, adjudicated not only the respective legal rights of the parties but also took steps toward decreeing a proper remedy. Thus in its January 20, 1998 order, the court resolved the merits of the Hospitals' claims, and with its April 30, 1998 order, directed the Secretary to calculate the amount of outlier payments due to the Hospitals and to make payment accordingly. This latter order has spawned some confusion about our jurisdiction because of the general

rule applicable to civil actions that "where assessment of damages or awarding of other relief remains to be resolved," a district court's judgment is not " 'final' within the meaning of 28 U.S.C. § 1291." *Liberty Mut. Ins. Co. v. Wetzel,* 424 U.S. 737, 744, 96 S.Ct. 1202, 47 L.Ed.2d 435 (1976); *see also A & S Council Oil Co. v. Lader,* 56 F.3d 234, 238 (D.C.Cir.1995) (holding that an order establishing liability but referring the issue of damages to arbitration is not final). For it is clear that neither of the district court's orders resolved the precise quantum of payments to be made to the Hospitals.

This rule of finality does not apply here, however, because this is not an appeal from an ordinary civil judgment rendered by the district court. With both of their claims, the Hospitals challenged the Secretary's actions under section 10(e) of the Administrative Procedure Act, 5 U.S.C. § 706(2). As we have often observed, "[w]hen a final agency action is challenged under the APA in district court, if the relevant substantive statute does not provide for direct review in the court of appeals, the district court does not perform its normal role" but instead "sits as an appellate tribunal." *PPG Indus., Inc. v. United States,* 52 F.3d 363, 365 (D.C.Cir.1995) (quoting *Marshall County Health Care Auth. v. Shalala,* 988 F.2d 1221, 1225 (D.C.Cir.1993)); *accord James Madison Ltd. v. Ludwig,* 82 F.3d 1085, 1096 (D.C.Cir.1996) ("Generally speaking, district courts reviewing agency action under the APA's arbitrary and capricious standard do not resolve factual issues, but operate instead as appellate courts resolving legal questions."), *cert. denied,* 519 U.S. 1077, 117 S.Ct. 737, 136 L.Ed.2d 676 (1997). Whether it is a court of appeals or a district court, "[u]nder settled principles of

administrative law, when a court reviewing agency action determines that an agency made an error of law, the court's inquiry is at an end: the case must be remanded to the agency for further action consistent with the corrected legal standards." *PPG Indus.*, 52 F.3d at 365; *see also South Prairie Constr. Co. v. Local No. 627, Int'l Union of Operating Eng'rs*, 425 U.S. 800, 806, 96 S.Ct. 1842, 48 L.Ed.2d 382 (1976); *SEC v. Chenery Corp.*, 318 U.S. 80, 94-95, 63 S.Ct. 454, 87 L.Ed. 626 (1943). Once, therefore, the district court held that the Secretary had misinterpreted § 1395ww(d)(5)(A)(iv), it should have remanded to the Secretary for further proceedings consistent with its conception of the statute. Not only was it unnecessary for the court to retain jurisdiction to devise a specific remedy for the Secretary to follow, but it was error to do so. *See Ommaya v. National Insts. of Health*, 726 F.2d 827, 830 (D.C.Cir.1984) ("If MSPB relied on incorrect legal grounds, it would be error for this court to enforce without first remanding for agency examination of the evidence and proper fact-finding.") (quoting *White v. United States Dep't of the Army*, 720 F.2d 209, 210 (D.C.Cir.1983)). Accordingly, because that was all that the district court had the power to do, we construe its January 20, 1998 order as a remand to the Secretary, and ignore, for jurisdictional purposes, its later order on specific relief.

Of course, properly characterizing the district court's order as a remand does not, without more, resolve our jurisdictional quandary, for a "remand order usually is not a final decision." *NAACP v. United States Sugar Corp.*, 84 F.3d 1432, 1436 (D.C.Cir.1996). We have recognized "an exception to this general rule, however, where the agency to

which the case is remanded seeks to appeal and it would have no opportunity to appeal after the proceedings on remand." *Occidental Petroleum Corp. v. SEC,* 873 F.2d 325, 330 (D.C.Cir.1989). Animating this principle is a pragmatic concern. Because an agency must conduct its proceedings and render its decision pursuant to the legal standard that the district court articulates in its remand order, "[u]nless another party appeals [the agency's subsequent] decision, the correctness of the district court's legal ruling will never be reviewed by the court of appeals, notwithstanding the agency's conviction that the ruling is erroneous." *Id.* Here, were the Secretary unable to appeal the district court's decision at this point, on remand she would have to interpret paragraph (5)(A)(iv) as the district court has construed it, and disburse millions of dollars in retroactive outlier payments to various Medicare-provider hospitals. Absent an appeal from that decision by one of the Hospitals, the Secretary would have no opportunity to challenge the legal basis for the disbursements. Our jurisdiction is therefore proper because the Secretary's appeal falls within the exception recognized in *Occidental Petroleum.* Additionally, vested with jurisdiction to review the Secretary's appeal under § 1291, we may also consider the Hospitals' cross-appeal of the district court's grant of summary judgment to the Secretary on their arbitrary and capricious agency-action claim. *See United States Sugar Corp.,* 84 F.3d at 1436.

B. *The Secretary's Appeal*

Turning first to the Secretary's challenge, we face a question of statutory interpretation that the district

court resolved in the affirmative: whether, under § 1395ww(d)(5)(A)(iv), the Secretary must make retroactive reimbursements to ensure that aggregate outlier payments during any given fiscal year constitute at least five percent of estimated or projected DRG- related payments. Because we may set aside agency action only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), we accord no particular deference to the judgment of the district court when conducting our review. *See HCA Health Servs. v. Shalala,* 27 F.3d 614, 616 (D.C.Cir.1994); *Hennepin County v. Sullivan,* 883 F.2d 85, 91 (D.C.Cir.1989) ("Our review proceeds as if this case were an immediate appeal from a decision reached after an administrative hearing on the record."); *Biloxi Reg'l Med. Ctr. v. Bowen,* 835 F.2d 345, 348-49 (D.C.Cir.1987).

We initiate statutory analyses of the sort presented here by first asking whether "Congress has directly spoken to the precise question at issue." *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 842, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984). For if after "exhaust[ing] the traditional tools of statutory construction," *Natural Resources Defense Council, Inc. v. Browner,* 57 F.3d 1122, 1125 (D.C.Cir.1995) (quoting *Chevron,* 467 U.S. at 843 n. 9, 104 S.Ct. 2778), we ascertain that Congress's intent is clear, "that is the end of the matter." *Chevron,* 467 U.S. at 842, 104 S.Ct. 2778. But "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843, 104 S.Ct. 2778. Where judicial review is refracted through this analytic prism, the

"view of the agency charged with administering the statute is entitled to considerable deference; and to sustain it, we need not find that it is the only permissible construction that [the agency] might have adopted." *Chemical Mfrs. Ass'n v. Natural Resources Defense Council, Inc.*, 470 U.S. 116, 125, 105 S.Ct. 1102, 84 L.Ed.2d 90 (1985).

Contending that the statutory language boasts an ambiguity, the Secretary maintains that she has reasonably construed paragraph (5)(A)(iv) as prescribing a specific methodology that she must follow when setting outlier thresholds at the beginning of each fiscal year. Under the Secretary's interpretation, paragraph (5)(A)(iv) mandates that she must select outlier thresholds which, when tested against historical data, will likely produce aggregate outlier payments totaling between five and six percent of projected or estimated DRG-related payments. Because, under the Secretary's construction, paragraph (5)(A)(iv) speaks only to how she is to calculate outlier thresholds for the forthcoming year, the Secretary posits that she has no obligation to ensure that actual outlier payments for the year total five percent of projected DRG-related payments.

Advocating a results-oriented approach, however, the Hospitals argue, and the district court agreed, that the Secretary's interpretation contradicts the unambiguous meaning of paragraph (5)(A)(iv). The textual lodestar guiding their plain-meaning critique is the single phrase "payments made." According to the Hospitals, by indicating in paragraph (5)(A)(iv) that "the total amount of the additional payments *made* . . . may not be less than 5 percent" of total DRG-related payments "estimated or projected to be made,"

42 U.S.C. § 1395ww(d)(5)(A)(iv) (Supp. IV 1986) (emphasis added), Congress unmistakably meant that the total amount of additional payments *actually made* during a fiscal year must meet the five-percent target. During years in which the Secretary's chosen thresholds yield outlier payments that fall short of the statutory mark, the Hospitals' interpretation would require the Secretary to bridge the difference by recalibrating outlier variables and making retroactive payments accordingly.

Standing alone, however, the phrase "payments made" hardly conveys a single meaning, much less the one that the Hospitals advance. As it is employed in paragraph (5)(A)(iv), "payments made" is "simply an adjectival phrase, not a verbial phrase indicating the past tense, and hence allows alternative temporal readings." *United States Dep't of the Treasury v. FLRA,* 960 F.2d 1068, 1072 (D.C.Cir.1992). It is not unlike the phrase "recognized as reasonable," which the Supreme Court, quoting favorably from our decision in *Administrators of the Tulane Educational Fund v. Shalala,* 987 F.2d 790 (D.C.Cir.1993), held "does not tell us whether Congress means to refer the Secretary to action already taken or to give directions on actions about to be taken." *Regions Hosp. v. Shalala,* 522 U.S. 448, __, 118 S.Ct. 909, 916, 139 L.Ed.2d 895 (1998) (quoting *Tulane Educ. Fund,* 987 F.2d at 796). Evincing the same syntactical equivalence, the phrase "payments made" in paragraph (5)(A)(iv), though certainly capable of accommodating the Hospitals' interpretation, can just as easily be read to reflect Congress's intent to "give directions on actions about to be taken." *Id.* In other words, instead of embodying a retrospective inquiry into the amount of outlier payments that *have been* made, the phrase

"payments made under this subparagraph" might just as plausibly reflect a prospective command to the Secretary about how to structure outlier thresholds for payments to be made in advance of each fiscal year. *Cf. Regions Hosp.*, 522 U.S. at __, 118 S.Ct. at 916 ("[T]he phrase 'recognized as reasonable' might mean costs the Secretary (1) *has* recognized as reasonable . . ., or (2) *will* recognize as reasonable. . . ."). Ultimately, whether the phrase is "recognized as reasonable," "adversely affected," or "payments made," it is difficult to divine with much confidence the pellucid intent of Congress because "[t]he language, in short, is ambiguous." *United States Dep't of the Treasury,* 960 F.2d at 1072 (describing as ambiguous the phrase "adversely affected"); *accord Tulane Educ. Fund,* 987 F.2d at 796.

Hoping to stave off judicial review under *Chevron*'s deferential second step, the Hospitals attempt to resuscitate their plain-meaning interpretation by contrasting the two ways in which Congress modified the word "made" in paragraph (5)(A)(iv). When it first appears, "made" is used without modifiers to describe the "total amount of the additional payments made under this subparagraph"; later, the word materializes to indicate that the total amount of outlier payments just described may not be less than five percent "of the total payments projected or estimated to be made" for DRG-related payments. 42 U.S.C. § 1395ww(d)(5)(A)(iv). Because, the Hospitals reason, Congress employed words of estimation and projection to modify the total amount of DRG-related payments "to be made" but neglected to do so when describing the total amount of outlier payments "made," it must have intended

that total outlier payments actually made during a fiscal year would equal at least five percent of estimated or projected DRG-related payments.[2]

Whatever logic this internal construction of paragraph (5)(A)(iv) enjoys, to prevent statutory interpretation from degenerating into an exercise in solipsism, "we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law." *United States Nat'l Bank v. Independent Ins. Agents of Am., Inc.*, 508 U.S. 439, 455, 113 S.Ct. 2173, 124 L.Ed.2d 402 (1993) (quoting *United States v. Heirs of Boisdore*, 49 U.S. (8 How.) 113, 122,

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2. The Hospitals cite only to this court's decision in *Washington Hospital Center v. Bowen*, 795 F.2d 139 (D.C.Cir.1986), to buttress their argument that the plain meaning of "made" can be inferred from the different language that Congress used to modify that word in paragraph (5)(A)(iv). That decision misses the mark, however. In *Washington Hospital Center*, we presumed that when Congress amended a pre-existing section of the Medicare statute by adding and deleting certain words, it must have intended the amended provision to have a different meaning from its predecessor provision. *Id.* at 146. More on point for the Hospitals, though they did not cite it, would be the canon of construction that posits that "where Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23, 104 S.Ct. 296, 78 L.Ed.2d 17 (1983); *accord Independent Bankers Ass'n of Am. v. Farm Credit Admin.*, 164 F.3d 661, 667 (D.C.Cir.1999). Of course, "[c]anons of construction are, after all, only aids in the process of statutory construction, nothing more, nothing less." *Eagle-Picher Indus. v. United States EPA*, 759 F.2d 922, 927 n. 6 (D.C.Cir.1985). As we demonstrate, *infra*, this canon does not resolve the ambiguity in paragraph (5)(A)(iv).

12 L.Ed. 1009 (1850)). Under *Chevron* step one, "we consider not only the language of the particular statutory provision under scrutiny, but also the structure and context of the statutory scheme of which it is a part." *Illinois Pub. Tele. Ass'n v. FCC*, 117 F.3d 555, 568 (D.C.Cir.), *modified*, 123 F.3d 693 (1997), *cert. denied*, 523 U.S. 1046, 118 S.Ct. 1361, 140 L.Ed.2d 511 (1998); *accord Conroy v. Aniskoff*, 507 U.S. 511, 515, 113 S.Ct. 1562, 123 L.Ed.2d 229 (1993) ("[T]he meaning of statutory language, plain or not, depends on context."); *Davis v. Michigan Dep't of Treasury*, 489 U.S. 803, 809, 109 S.Ct. 1500, 103 L.Ed.2d 891 (1989) ("[W]ords of a statute must be read in their context and with a view to their place in the overall statutory scheme."). By examining paragraph (5)(A)(iv) in its immediate statutory context, any putative clarity that that provision might arguably have quickly recedes to ambiguity once again.

Preceding paragraph (5)(A)(iv) by two paragraphs, § 1395ww(d)(3)(B) provided during the time relevant to this litigation:

> The Secretary shall reduce each of the average standardized amo[illegible].s under subparagraph (A) . . . by a proportion equal to the proportion *(estimated by the Secretary)* of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments described in paragraph (5)(A) (relating to outlier payments). . . .

42 U.S.C. § 1395ww(d)(3)(B) (Supp. IV 1986) (emphasis added). Not only does this provision expressly indicate that

total outlier payments are to be estimated by the Secretary, but it also employs language that closely parallels the language that later appears in paragraph (5)(A)(iv). In our endeavor to determine whether the "total amount of the additional payments made under this subparagraph" contemplates outlier payments actually made or those estimated to be made, we find it significant that in paragraph (3)(B) Congress provided that the "amount of payments . . . which are additional payments described in paragraph (5)(A)" are to be "estimated by the Secretary." § 1395ww(d)(3)(B). Given that in paragraph (3)(B) it had already indicated that the Secretary would estimate the amount of outlier payments described in subparagraph (5)(A), Congress could have reasonably concluded that there was no need to provide expressly in paragraph (5)(A)(iv) that the phrase "payments made" referred to payments estimated to be made. Thus, whatever can be said for Congress's disparate modification of the word "made" in paragraph (5)(A)(iv), when we open the analytic aperture to examine that clause in its proper statutory context, the inherently ambiguous phrase "payments made" becomes no clearer.

Nor does a passing observation in the Conference Report that "the Secretary would be *required* to provide additional payments for outlier cases amounting to not less than 5 percent, and not more than 6 percent, of total projected or estimated DRG related payments," compel us to adopt the Hospitals' construction of the statute under *Chevron* step one. H.R. CONF. REP. No. 98-47, at 189 (1983), *reprinted in* 1983 U.S.C.C.A.N. 404, 479 (emphasis added). Ambiguous in its own right, this passage, if given the gloss that the

Hospitals advance, would chafe against the commentary in the Senate Report. Suggesting that paragraph (5)(A)(iv) reflects the prospective inquiry that the Secretary advocates, the Senate Report provides that the "[t]otal *expected* payments resulting from this policy will be not less than 5 percent, nor more than 6 percent, of total medicare payments to hospitals." S.REP. No. 98-23, at 51, *reprinted in* 1983 U.S.C.C.A.N. 143, 191 (emphasis added). The only conclusion that we can safely draw from these seemingly contradictory passages is that "the little legislative history that exists for [paragraph (5)(A)(iv)] is as ambiguous as the statute itself." *Deaf Smith County Grain Processors, Inc. v. Glickman,* 162 F.3d 1206, 1212 (D.C.Cir.1998).

Ultimately, neither the text, structure, nor legislative history of paragraph (5)(A)(iv) illuminates Congress's unambiguous intent. Although the Hospitals' interpretation, and the one that the district court adopted, is plausible, it is not the "only possible interpretation," *Sullivan v. Everhart,* 494 U.S. 83, 89, 110 S.Ct. 960, 108 L.Ed.2d 72 (1990), and it certainly is not "an inevitable one." *Regions Hosp.,* 522 U.S. at __, 118 S.Ct. at 917. Because we find the statute ambiguous, we proceed to assess whether the Secretary's interpretation of paragraph (5)(A)(iv) is "reasonable and consistent with the statutory scheme and legislative history." *Cleveland v. United States Nuclear Regulatory Comm'n,* 68 F.3d 1361, 1367 (D.C.Cir.1995).

In marking off the metes and bounds of our review under the second step of *Chevron,* we accord particular deference to the Secretary's interpretation of paragraph (5)(A)(iv) "given the tremendous complexity of the Medicare statute."

Appalachian Reg'l Healthcare, Inc. v. Shalala, 131 F.3d 1050, 1054 (D.C.Cir.1997); *accord Methodist Hosp. v. Shalala,* 38 F.3d 1225, 1229 (D.C.Cir.1994). The Hospitals, however, urge us not to defer in any way to the Secretary's interpretation of paragraph (5)(A)(iv) because, they contend, that provision does not delegate interpretative authority to the Secretary but explicitly limits her discretion. The problem with this argument, of course, is that it assumes the truth of the proposition that we just rejected. Were paragraph (5)(A)(iv) truly "an explicit limitation on the Secretary's discretion," Br. of Hosps. at 40, there would be no need to analyze the provision under *Chevron* step two. While paragraph (5)(A)(iv) is certainly designed to regulate the Secretary's discretion to some extent, as we have already concluded, the precise contours of that provision are hardly explicit but are instead ambiguous. Nor is it problematic, as the Hospitals suggest, that Congress did not expressly delegate interpretative authority to the Secretary in paragraph (5)(A)(iv). Deference to agency interpretation is warranted "when Congress has left a gap for the agency to fill pursuant to an express or implied delegation of authority to the agency." *Chevron,* 467 U.S. at 843-44, 104 S.Ct. 2778 (internal quotations omitted). Where, as here, Congress enacts an ambiguous provision within a statute entrusted to the agency's expertise, it has "implicitly delegated to the agency the power to fill those gaps." *National Fuel Gas Supply Corp. v. FERC,* 811 F.2d 1563, 1569 (D.C.Cir.1987); *see also Chevron,* 467 U.S. at 843-44, 104 S.Ct. 2778.

Equally untenable is the Hospitals' argument that the Secretary's interpretation is not entitled to deference because she did not adopt it through either formal rulemaking or

adjudication. But as our precedents make clear, "an agency need not promulgate a legislative rule setting forth its interpretation of a statutory term for that interpretation to be entitled to deference." *Association of Bituminous Contractors, Inc. v. Apfel*, 156 F.3d 1246, 1251-52 (D.C.Cir.1998). In fact, "[e]ven if the legal briefs contained the first expression of the agency's views, under the appropriate circumstances we would still accord them deference so long as they represented the agency's 'fair and considered judgment on the matter.' " *United Seniors Ass'n v. Shalala*, 182 F.3d 965, 971 (D.C.Cir.1999) (quoting *Auer v. Robbins*, 519 U.S. 452, 462-63, 117 S.Ct. 905, 912, 137 L.Ed.2d 79 (1997)); *see National Wildlife Fed'n v. Browner*, 127 F.3d 1126, 1129 (D.C.Cir.1997) ("The mere fact that an agency offers its interpretation in the course of litigation does not automatically preclude deference to the agency."); *Tax Analysts v. IRS*, 117 F.3d 607, 613 (D.C.Cir.1997).

There is no reason to suspect that the Secretary's interpretation of paragraph (5)(A)(iv) embodies anything other than her fair and considered opinion. In a final rule published on January 3, 1984, the Secretary articulated the same interpretation of paragraph (5)(A)(iv) that she has pressed before both us and the district court. *See* 49 Fed.Reg. 234, 265 (1984). With that rule, she not only observed that under her interpretation "there is no necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria," *id.*, but she also admonished Medicare providers that, in the event she overestimated the amount of outlier payments, she would "not adjust the DRG rates to compensate hospitals for funds that were not actually

paid for outlier cases." *Id.* at 266. Even if, as the Hospitals complain, the final rule failed to provide a "cogent explanation" of the policies undergirding the Secretary's interpretation, the fact remains that for the past fifteen years, the Secretary has never wavered from that interpretation. We are confident that the interpretation of paragraph (5)(A)(iv) under review embodies the Secretary's "fair and considered judgment on the matter." *Auer,* 519 U.S. at 462-63, 117 S.Ct. at 912. It, accordingly, demands deference from the judiciary.

Having settled on the scope of our review, we have no difficulty concluding that the Secretary has advanced a reasonable interpretation of paragraph (5)(A)(iv). Congress established outlier payments because it recognized that "there will be cases within each [DRG] that will be extraordinarily costly to treat . . . because of severity of illness or complicating conditions, and [will] not [be] adequately compensated for under the DRG payment methodology." S.REP. NO. 98-23, at 51 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 191. But as the term "outlier" suggests, these payments were not intended to subsidize hospitals simply for treatments, which in absolute terms, were extraordinarily costly or lengthy. Rather, Congress directed the Secretary to provide "additional payments for cases which are extraordinarily costly to treat, *relative to other cases* within the DRG." *Id.* (emphasis added); *accord* H.R.REP. No. 98-25, at 134-35 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 353-54 ("Your Committee is concerned that under the prospective payment system, there will be cases within each [DRG] that will be extraordinarily costly to treat, relative to other cases within that DRG. . . ."). Thus the House version would have required the Secretary to tender outlier payments

only when a patient's length of stay exceeded by thirty days the average length of stay for cases in that same DRG, *see* H.R.REP. NO. 98-25, at 135, *reprinted in* 1983 U.S.C.C.A.N. at 354, while the Senate bill, which the Conference Committee adopted, authorized outlier payments for cases in which a patient's length of stay eclipsed the mean length of stay for discharges within that same DRG by a fixed number of days or standard deviations. *See* 42 U.S.C. § 1395ww(d)(5)(A)(i) (Supp. IV 1986); S.REP. NO. 98-23, at 51, *reprinted in* 1983 U.S.C.C.A.N. at 191; H.R. CONF. REP. NO. 98-47, at 188 (1983), *reprinted in* 1983 U.S.C.C.A.N. 404, 478.

The Secretary's interpretation of paragraph (5)(A)(iv) evinces far greater fidelity to Congress's conception of outlier payments than does the view espoused by the Hospitals. Under the Secretary's reading of the statute, if it turns out that actual outlier payments do not meet the five-percent target at the end of the fiscal year, it is because the lengths of stay for DRGs in that year proved to be shorter than the historical averages reflected in the data on which the Secretary based her threshold calculations. Whether it is because hospitals became more efficient or a miracle drug was introduced during the year, the shorter lengths of stay mean that there were fewer extraordinarily costly cases during the year. In other words, there were fewer outliers — and therefore, fewer outlier payments needed to be made.

Under the Hospitals' interpretation, however, regardless of actual costs or inpatient lengths of stay during a fiscal year, Medicare providers are guaranteed a substantial and fixed sum of outlier payments. As they read the statute, even

during a fiscal year in which the length of stay for every inpatient discharge in every DRG in every hospital equaled or exceeded by just a day the mean length of stay for each respective DRG, the Secretary would nonetheless have to reward hospitals with additional "outlier" payments totaling five percent of the entire DRG budget. One need not be well versed in the discipline of statistics to recognize that such insignificant deviations from the mean do not constitute outliers. To sanction the Hospitals' interpretation of paragraph (5)(A)(iv) would not only require us to assume that Congress did not appreciate the meaning of outlier — a term, it should be noted, that appears throughout both the legislative history and the text of the Medicare statute — but it would also transform the character of the outlier-payment regime from a system intended to insulate hospitals from aberrational and extraordinary costs into nothing more than an entitlement program for Medicare providers. Such was hardly Congress's intent, for if anything, Congress indicated that it was "equally concerned that adjustments may be required for cases which have an *unusually short* length of stay or which are significantly less costly than the DRG payment." H.R. CONF. REP. No. 98- 47, at 478, *reprinted in* 1983 U.S.C.C.A.N. at 478 (emphasis added); *see also* H.R.REP. No. 98-25, at 135, *reprinted in* 1983 U.S.C.C.A.N. at 354 ("The Secretary would be required to study . . . the appropriateness of, and necessity for, adjustments in payment rates for extremely short lengths of stay within a DRG. . . ."). Proposals like these reflect a reluctance to reimburse Medicare providers at rates grossly disproportionate to the cost of treatment. We find it unlikely that Congress nevertheless would have wanted hospitals to reap additional compensation over and above the standard DRG payment

where treatment costs for a particular discharge were not extraordinarily costly relative to the mean costs for that DRG.

Moreover, compared to the Hospitals' interpretation of paragraph (5)(A)(iv), the Secretary's reading better harmonizes each of the four clauses in paragraph (5)(A). As did the district court, the Hospitals struggle to reconcile their conception of the fourth clause with the language of the third, which provides that the amount of each outlier payment "shall approximate the marginal cost of care beyond the cutoff point applicable" for each DRG. 42 U.S.C. § 1395ww(d)(5)(A)(iii) (Supp. IV 1986). Under the Hospitals' construction of the statute, outlier payments might bear little relationship to the marginal cost of care. At the end of each fiscal year, if actual outlier payments fell short of the five-percent target, the Secretary would be required retroactively to supplement those payments to satisfy the difference. Depending on how great that initial disparity was, by the time that these curative outlays were made, the newly computed outlier payments might not approximate anything close to the marginal cost of care as paragraph (5)(A)(iii) mandates. By contrast, outlier payments under the Secretary's interpretation will always approximate the marginal cost of care because when determining where to set outlier thresholds for DRGs at the beginning of each fiscal year, she directly factors the marginal cost of care into her calculus.

Echoing the district court's holding, the Hospitals discount paragraph (5)(A)(iii) as merely a "guideline" while contending that paragraph (5)(A)(iv) operates "as a limitation on the Secretary's discretion." *County of Los Angeles*, 992

F.Supp. at 32. Based on this view, the Secretary is supposed to set outlier thresholds at the beginning of each year "at marginal cost and then, when actual outlier data is known, adjust[ ] the final payments to ensure that the Secretary has met her statutory obligation to the providers." *Id.* at 31. Why this parsing of the statutory language is more reasonable than that of the Secretary's — much less compelled as an unambiguously plain reading of the provision, as the Hospitals have urged — is not at all clear. After all, paragraph (5)(A)(iii) employs mandatory language of the sort not normally used if all that Congress intended to do was to offer a discretionary guideline for the Secretary to follow. *See* § 1395ww(d)(5)(A)(iii) ("The amount of such additional payment under clauses (i) and (ii) *shall* be determined by the Secretary and *shall* approximate the marginal cost of care. . . .") (emphasis added). Nevertheless, even were the Hospitals' synthesis of the third clause into the remainder of paragraph (5)(A) plausible, it would not be enough to impugn the otherwise reasonable interpretation that the Secretary has advanced since "we need not find that it is the only permissible construction that [the Secretary] might have adopted but only that [her] understanding of this very 'complex statute' is a sufficiently rational one to preclude a court from substituting its judgment for that of [the Secretary]." *Young v. Community Nutrition Inst.*, 476 U.S. 974, 981, 106 S.Ct. 2360, 90 L.Ed.2d 959 (1986) (internal quotation omitted).

Moreover, the Secretary's interpretation avoids the substantial administrative burden attendant with the Hospitals' vision of paragraph (5)(A)(iv). It strains credulity to assume that Congress would have directed the Secretary

to establish outlier thresholds in advance of each fiscal year, *see* § 1395ww(d)(3)(B), (d)(6), and process millions of bills based on those figures, only to have her at the end of the year recalibrate those calculations, reevaluate anew each of the millions of inpatient discharges under the revised figures, and disburse a second round of payments. As we have held in an analogous context, "[u]nder these circumstances, retroactive corrections would cause a significant, if not debilitating, disruption to the Secretary's administration of the already-complex Medicare program." *Methodist Hosp.*, 38 F.3d at 1233. Nor is this administrative process rendered less awkward and unwieldy if, as the Hospitals suggest, the Secretary actively monitors outlier payments and adjusts the thresholds as the fiscal year unfolds. Apart from the tremendous resources that would be required to maintain such a vigilant watch over a program as expansive as Medicare, intermittently modifying outlier thresholds at various times during the year would mean that different hospitals would likely receive different outlier reimbursements for the same treatments based on nothing more than the fortuity of when they treated a patient.

By the same token, this uncertainty and fluidity in outlier-payment amounts under the Hospitals' interpretation lead us to the final virtue of the Secretary's construction. One of the touchstones of the Prospective Payment System, as its name suggests, is prospectively determined reimbursement rates that remain constant during the fiscal year. In setting, prior to each fiscal year, fixed outlier thresholds and per-diem reimbursement rates that are not later subject to retroactive correction, the Secretary promotes certainty and predictability of payment for not only hospitals

but the federal government — concerns that played a prominent role in Congress's decision to adopt PPS. *See* H.R.REP. No. 98-25, at 132, *reprinted in* 1983 U.S.C.C.A.N. at 351 ("The bill is intended to improve the medicare program's ability to act as a prudent purchaser of services, and to provide predictibility [*sic*] regarding payment amounts for both the Government and hospitals."). To be sure, we have previously speculated that "the real linchpin of the [PPS] system may not be that the exact reimbursement *figure* is known in advance, but rather may be that the hospital knows that nothing it does in providing services will lead to a higher reimbursement level." *Georgetown Univ. Hosp. v. Bowen,* 862 F.2d 323, 330 (D.C.Cir.1988) (*Georgetown II*). Yet while we, therefore, have recognized that retroactive corrections may not ultimately undermine PPS, we have emphasized that that "does not establish that a prospective-only policy is unreasonable." *Methodist Hosp.,* 38 F.3d at 1232.

In *Methodist Hospital,* we found the Secretary's decision not to recalculate retroactively the DRG wage index to be reasonable, in part, because the Secretary's prospective policy advanced the principles of PPS.[3] With language applicable to the present case, we held:

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3. The Hospitals cannot successfully distinguish *Methodist Hospital.* Admittedly, unlike the DRG wage index at issue in *Methodist Hospital,* outlier payments do not factor directly into every inpatient discharge. But outlier payments do influence indirectly the overall DRG payment rate that governs all discharges. As already discussed, pursuant to § 1395ww(d)(3)(B), the Secretary must reduce the standard DRG payment rate by a factor equal to the outlier

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> While retroactive adjustments might leave the "linchpin" of PPS intact, that does not mean that a prospective-only policy would not further, to some degree, the overall goals of PPS. . . . [H]ospitals, like other businesses, do make projections about future costs and service levels based on their experience and historical patterns. To the extent that the Secretary's prospectivity policy permits hospitals to rely with certainty on one additional element in the PPS calculation rate . . . the Secretary could reasonably conclude that it will promote efficient and realistic cost-saving targets.

Id. The same, quite reasonably, can be said of the Secretary's interpretation of paragraph (5)(A)(iv). Under her construction of the statute, at the outset of each fiscal year, hospitals know the point beyond which a patient's length of stay will trigger outlier payments and the corresponding rate at which they will be reimbursed for each day beyond the threshold. A less determinate policy would not only deprive hospitals of the

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(Cont'd)
payments that she predicts she will have to disburse during the forthcoming year. Nor is it accurate to claim, as the Hospitals do, that outlier payments are entirely divorced from PPS. As an initial matter, the provisions relating to outliers are contained in the same subsection of § 1395ww as those establishing the PPS regime. *See* § 1395ww(d). Moreover, Congress established outlier payments not as a distinct reimbursement methodology but as a carefully crafted supplement to PPS. For that reason, *Georgetown II*, which concerned retroactive adjustments under the pre-PPS "reasonable cost" system — clearly a payment methodology lacking any relationship to PPS — is inapposite.

ability to make accurate projections about outlier payments for the forthcoming year but also threaten them at the end of each year with the prospect of actually having to forfeit a portion of those payments to the Secretary; for as the Hospitals concede, under their interpretation, Medicare providers collectively would be bound to repay any portion of outlier payments that exceeded six percent of estimated DRG-related payments. *See* Br. of Hosps. at 31-32. We conclude that the Secretary has advanced a reasonable interpretation of an ambiguous statutory provision, and, therefore, reverse the judgment of the district court with respect to the Secretary's appeal.

C. *The Hospitals' Cross-Appeal*

Because outlier thresholds are measured by their distance from the mean length of stay, accurately forecasting outlier payments depends, in large part, on how closely the mean length of stay reflected in the Secretary's historical data reflects the actual average length of stay for that particular DRG. When setting outlier thresholds for fiscal years 1985-1986, the Secretary relied on the 1981 MEDPAR file, a database containing patient-specific data for a random sample of 20 percent of all Medicare-hospital discharges during 1981. Compiled during an era when Medicare still reimbursed hospitals under the reasonable-cost system, the 1981 MEDPAR file could not have predicted how, under PPS, the average length of stay for virtually all DRGs would eventually decline dramatically. The Hospitals observe, however, that by July 27, 1984, the Secretary had already collected data from 2.5 million discharges under PPS that indicated that the average length of stay for all DRGs had

declined from 9.5 days to 7.5 days under the new payment methodology. Pursuant to section 10(e) of the APA, 5 U.S.C. § 706(2)(A), the Hospitals claim that the Secretary acted arbitrarily and capriciously when she calculated outlier thresholds for 1985-1986 based on the 1981 MEDPAR file instead of the preliminary 1984 data and failed to explain adequately her decision. Rejecting the Hospitals' claim, the district court agreed with the Secretary that her decision to use the 1981 MEDPAR file over the more contemporaneous but preliminary 1984 data "was a rational choice between two imperfect databases." *County of Los Angeles*, 992 F.Supp. at 36.

Under the APA, we may set aside agency action found to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). Foreclosed from substituting our judgment for that of the agency, we do not set aside agency action lightly. *See Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983); *Petroleum Communications, Inc. v. FCC*, 22 F.3d 1164, 1172 (D.C.Cir.1994). Nevertheless, we intervene to ensure that the agency has "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action." *State Farm*, 463 U.S. at 43, 103 S.Ct. 2856. "Where the agency has failed to provide a reasoned explanation, or where the record belies the agency's conclusion, we must undo its action." *BellSouth Corp. v. FCC*, 162 F.3d 1215, 1222 (D.C.Cir.1999) (citation and quotation omitted).

The only contemporaneous explanation that the Secretary offered for using the 1981 MEDPAR file consisted

of two sentences in the Federal Register: "Based upon outlier and DRG payment data received through July 27, 1984, there is *no evidence* to suggest that total outlier payments are below the levels intended. Therefore, as discussed above, we are continuing to set the outlier thresholds on the basis of the 1981 MEDPAR data." 49 Fed.Reg. 34,728, 34,769 (1984) (emphasis added). We agree with the Ninth Circuit, which recently considered this same issue, that the Secretary's "explanation that there was *no* evidence of an outlier shortfall was simply not supported by the record before her and did not explain her failure to use the more recent data." *Alvarado Community Hosp. v. Shalala,* 155 F.3d 1115, 1122 (9th Cir.1998). Data that the Secretary possessed as late as July 27, 1984, indicated that the average length of stay for practically all DRGs had declined considerably under the nascent PPS program. More concretely, at that point during the fiscal year, outliers constituted only 1.9 percent of total PPS discharges instead of 5.4 percent as predicted. And while these conclusions were drawn from preliminary data, that data reflected 2.5 million patient discharges under PPS; the 1981 MEDPAR file, by contrast, contained 1.6 million discharge records. Failure to account for this trend is all the more perplexing insofar as the Secretary herself had anticipated that the average length of stay for DRGs would decline under PPS. In 1984 she observed that "[t]he most commonly accepted expectation about the PPS at the time of its inception was that it would result in shorter stays for Medicare patients. . . . [R]educed length of stay was to be one of the major vehicles through which hospital costs were to be controlled under the PPS." OFFICE OF RESEARCH & DEMONSTRATIONS, HEALTH CARE FIN. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. NO. 03231, REPORT TO

Appendix A

CONGRESS: IMPACT OF THE MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM 6-13 (1984). At bottom, for the Secretary to say that she had "no evidence to suggest that total outlier payments [were] below the levels intended," 49 Fed.Reg. at 34,769, runs "counter to the evidence before the agency" and "is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *State Farm*, 463 U.S. at 43, 103 S.Ct. 2856.

In her brief, the Secretary now contends that what she meant by "no evidence" was "no reliable evidence." To bolster this specific claim and her broader argument that the 1984 data were too suspect and incomplete to make accurate outlier projections, the Secretary appended to her summary judgment motion in the district court an affidavit from Rose Connerton, an official with the Health Care Financing Administration ("HCFA") who helped develop the outlier thresholds for 1985-1986. Essentially, the Connerton affidavit claims that the 1984 data were not complete and did not represent a random sample of cases, that because they were based on a partial year they would not reflect seasonal and regional variances, and that any analysis drawn from them would be skewed.[4] *See* J.A. 90 (Aff. of Connerton

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4. Through the Connerton affidavit, the Secretary attempts to dramatize the unreliability of the partial 1984 data. As of April 27, 1984, reported outliers constituted only 1.9 percent of total PPS discharges. *See* J.A. 71. By the end of fiscal year 1984, however, actual outlier payments ended up totaling 5.3 percent of total PPS payments, suggesting, Connerton avers, that the preliminary data were in fact unreliable. Although Connerton's calculations are accurate, the conclusions that she draws from them are subject to (Cont'd)

¶¶ 10, 12, 15). The Hospitals contend that the Connerton affidavit, having surfaced for the first time during litigation, is an impermissible post-hoc rationalization that the district court should have stricken. *See SEC v. Chenery Corp.*, 318 U.S. 80, 87-88, 63 S.Ct. 454, 87 L.Ed. 626 (1943); *Reeve Aleutian Airways, Inc. v. United States*, 889 F.2d 1139, 1144 (D.C.Cir.1989). Indeed, faced with a similar affidavit from Connerton, the Ninth Circuit held that the district court erred in considering it. *See Alvarado Community Hosp.*, 155 F.3d at 1124. Ultimately, we need not reach this question, for even were we inclined to accept everything in the Connerton affidavit, we would still remand to the Secretary for a more adequate justification for her database selection.

"A long line of precedent has established that an agency action is arbitrary when the agency offer[s] insufficient reasons for treating similar situations differently." *Transactive Corp. v. United States*, 91 F.3d 232, 237 (D.C.Cir.1996); *see also State Farm*, 463 U.S. 29, 57, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983); *Airmark Corp. v. FAA*, 758 F.2d 685, 691-92 (D.C.Cir.1985); *Local 777, Democratic Union Org. Comm. v. NLRB*, 603 F.2d 862, 872

(Cont'd)

debate. During a portion of fiscal year 1984, the Secretary erroneously provided hospitals with additional outlier payments for non-PPS-covered treatments, but never sought to recoup these surplus amounts. That outlier payments amounted to 5.3 percent that year thus may say less about the reliability of the 1984 data and more about the scope of the Secretary's clerical error. Whatever the reason, this dispute underscores the wisdom of Benjamin Disraeli's sardonic quip (attributed to him by Mark Twain) about the three great falsehoods: "lies, damn lies, and statistics."

(D.C.Cir.1978). Although maligning the 1984 data as too unreliable to calculate outlier thresholds for fiscal years 1985-1986, the Secretary nonetheless used those same data on August 31, 1984, to reduce across-the-board all 470 DRG weighting factors by 1.05 percent. *See* 49 Fed.Reg. 34,728, 34,770-71 (1984). Such an adjustment was necessary, the Secretary noted at the time, because "[t]he emerging experience under the prospective payment system" — an experience gleaned from the preliminary 1984 data — revealed that the different incentives that hospitals faced under PPS were producing unexpected distortions. *See id.* In making this correction, the Secretary expressly endorsed the reliability of the 1984 data: "To date, we have now analyzed 2.5 million discharges under the prospective payment system, which fully reflect the effect of those incentives, and we believe this affords us a better measure of the effect of coding improvements in the average case mix." *Id.* at 34,771. Moreover, in responding to a question about the legitimacy of the preliminary data during a 1984 congressional oversight hearing, the HCFA Administrator responded that "[o]ur sample now is based on approximately 50 percent of all of the claims or the admissions that we had projected for this year. We think that's a fairly representative sample." *Adjustments in Medicare's Prospective Payment System: Hearing Before the Subcomm. on Health of the Comm. on Fin.*, 98th Cong. 62 (statement of Mr. Davis, Administrator, HCFA). In sum, the Secretary has inadequately explained why the 1984 data were suitable for one significant calculation but unreliable for another. Her sole justification is that preliminary data may be used to make across-the-board adjustments, as was done to reduce all DRG weighting factors by 1.05 percent, but that they may not be

used for setting outlier thresholds because a unique standard deviation must be calculated for each of the 470 DRGs. What renders this explanation inadequate is that DRG weighting factors, like outlier thresholds, are ordinarily determined on a DRG-by-DRG basis. Indeed, the very purpose of a DRG weighting factor is to reflect the different costs of treating minor and major illnesses; to do so, each DRG must be assigned its own unique weight based on the cost and complexity of treatment peculiar to that DRG. The Secretary's proffered distinction is thus not reasonable. She may in her discretion, of course, rely on preliminary data to make an across-the-board adjustment to variables that ordinarily are determined on a case-by-case basis. But when she does so, she must be prepared to explain why she cannot also use that data to make a similar adjustment to variables that are also typically calculated on an individual basis. As broad as her discretion is, it "is not a license to . . . treat like cases differently." *Airmark Corp.*, 758 F.2d at 691; *accord Teva Pharms., USA, Inc. v. FDA*, 182 F.3d 1003, 1010-11 (D.C.Cir.1999); *Transactive Corp.*, 91 F.3d at 237; Local 777, 603 F.2d at 872.

This case must therefore be remanded to the Secretary to allow her either to recalculate outlier thresholds for fiscal years 1985-1986 or to offer a reasonable explanation for refusing to use the 1984 data in setting outlier thresholds during those years. In reaching this conclusion, we necessarily part ways with the Ninth Circuit, which, in *Alvarado Community Hospital*, chose not to remand to the Secretary, but instead ordered her to adjust outlier thresholds for fiscal year 1985 based on final 1984 data. *Alvarado Community Hosp.*, 155 F.3d at 1125. As the Supreme Court

has instructed, however, where "the record before the agency does not support the agency action, . . . the proper course, except in rare circumstances, is to remand to the agency for additional investigation or explanation." *Florida Power & Light Co. v. Lorion,* 470 U.S. 729, 744, 105 S.Ct. 1598, 84 L.Ed.2d 643 (1985); *see also Dunlop v. Bachowski,* 421 U.S. 560, 574-75, 95 S.Ct. 1851, 44 L.Ed.2d 377 (1975) ("Where the statement inadequately discloses his reasons, the Secretary may be afforded opportunity to supplement his statement."), *overruled on other grounds by Furniture & Piano Moving v. Crowley,* 467 U.S. 526, 549-50 n. 22, 104 S.Ct. 2557, 81 L.Ed.2d 457 (1984). We find no reason to depart from that course here. While we have identified significant inconsistencies and gaps in the Secretary's rationale for using the 1981 MEDPAR file, bedrock principles of administrative law preclude us from declaring definitively that her decision was arbitrary and capricious without first affording her an opportunity to articulate, if possible, a better explanation. *See Bechtel v. FCC,* 10 F.3d 875, 887 (D.C.Cir.1993); *Philadelphia Gas Works v. FERC,* 989 F.2d 1246, 1251 (D.C.Cir.1993); *Sullivan Indus. v. NLRB,* 957 F.2d 890, 905 n. 12 (D.C.Cir.1992); *Tex Tin Corp. v. EPA,* 935 F.2d 1321, 1324 (D.C.Cir.1991); *see also Checkosky v. SEC,* 23 F.3d 452, 463 (D.C.Cir.1994) (Silberman, J., concurring) (citing some of the "many instances where we have remanded to an agency for a better explanation before finally deciding that the agency's action was arbitrary and capricious"). Because we fail to perceive any "rare circumstances" that would warrant a break with established administrative practice, we adhere to the proper course of remanding this matter to the Secretary.

III. Conclusion

For the foregoing reasons, we reverse the judgment of the district court with respect to the Secretary's appeal, and remand with instructions to enter judgment in the Secretary's favor. As for the Hospitals' cross-appeal, we reverse the judgment of the district court, and instruct it to remand the case to the Secretary for further proceedings consistent with this opinion.

So ordered.

APPENDIX B — OPINION OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA DATED JANUARY 20, 1998 AND AMENDED JANUARY 23, 1998

COUNTY OF LOS ANGELES,

Plaintiff,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

PASADENA HOSPITAL ASSOCIATES, Ltd.,

Plaintiff,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

ROBERT PACKER HOSPITAL, et al.,

Plaintiffs,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

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SUMMIT HOSPITAL CORPORATION,

Plaintiff,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

UNIVERSAL HEALTH SERVICES, INC., et al.,

Plaintiffs,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

GALEN MEDICAL CORPORATION, et al.,

Plaintiffs,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

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NU-MED BALDWIN PARK, INC., et al.,

Plaintiffs,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

CHARTER MEDICAL CORPORATION,

Plaintiff,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

HOSPITAL CORPORATION OF NORTHWEST, INC., et al.,

Plaintiffs,

v.

Donna E. SHALALA, Secretary of Health and Human Services,

Defendant.

Appendix B

Civil Action Nos. 93-146 SSH, 93-147 SSH, 93-479 SSH, 93-692 SSH, 93-836 SSH, 93-837 SSH, 93-1188 SSH, 93-2069 SSH and 94-1485 SSH.

United States District Court,
District of Columbia.

Jan. 20, 1998.

As Amended Jan. 23, 1998.

* * *

OPINION

STANLEY S. HARRIS, District Judge.

This matter is before the Court on defendant's motion for summary judgment, plaintiffs' motion for summary judgment and opposition to defendant's motion, defendant's opposition and reply, and plaintiffs' reply. Also before the Court are plaintiffs' motion to strike portions of the declaration of Rose Connerton and defendant's opposition thereto. Upon consideration of those motions, the Court enters an Order in accordance with the reasoning set forth below. Although "[f]indings of fact and conclusions of law are unnecessary on decisions of motions under Rule . . . 56," the Court nonetheless sets forth its analysis. Fed.R.Civ.P. 52(a).

Appendix B

BACKGROUND

The Medicare program, established in 1965, provides federally funded health insurance for the elderly and disabled. *See* 42 U.S.C. § 1395 *et seq.* (1988). Until 1983, hospitals were reimbursed based on their "reasonable costs" or "customary charges" for services provided. *Id.* at § 1395f(b). In 1983, in response to escalating Medicare expenditures, Congress revised the system for reimbursing hospitals. The new regime, known as the Prospective Payment System ("PPS"), pays hospitals a fixed, predetermined "prospective payment rate" for each hospital discharge. *Id.* at § 1395ww(d)(1). The prospective rates paid to hospitals for Medicare beneficiaries vary according to the category of illness treated, or "diagnosis related group" ("DRG"). *Id.* at § 1395ww(d). The rate for a DRG is intended to reflect the average resources required to treat cases within that DRG.

When the new PPS system was proposed, public hospitals expressed concern that they would be at a disadvantage because they had sicker than average patients. *See* Hearings Before the Comm. on Ways and Means, H. Hrg. No. 98-3, at 218 (1983). In order to address this problem, Congress provided for additional payments for what are characterized as "outlier" cases, *i.e.*, ones involving an unusually long length of stay ("day outliers") or extraordinarily high cost ("cost outliers"). 42 U.S.C. § 1395ww(d)(5)(A); *see also* Hearing Before the Subcomm. on Health of the Senate Comm. on Finance, S. Hrg. 98-60, pt. 1, at 50 (1983). Each year, the Secretary of the United States Department of Health and Human Services ("the Secretary") establishes thresholds for determining when a

specific case qualifies as an outlier. 42 U.S.C. § 1395ww(d)(5)(A)(i)-(ii). The statute further provides that the outlier payment "shall approximate the marginal cost of care" beyond the thresholds, and that "the total amount of the additional payments made . . . for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." *Id.* at § 1395ww(d)(5)(A)(iii)-(iv). In order to comply with the statute, each fiscal year ("FY") the Secretary sets the outlier thresholds at a level which she estimates will result in outlier payments being five to six percent of total Medicare payments projected to be made that fiscal year.[1]

In FYs 1985 and 1986, actual outlier payments were less than five percent of total DRG prospective payments.[2] Plaintiffs, the owners of hospitals qualified as Medicare providers, argue that they are entitled to additional outlier payments for FYs 1985 and 1986 because the statute states that actual outlier payments for a fiscal year must represent

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1. In FYs 1985 and 1986, at issue here, the outlier thresholds were set at a level which the Secretary projected would result in outlier payments representing the permissible minimum — 5.0% — of projected total DRG prospective payments. 49 Fed.Reg. 34728, 34768 (Aug. 31, 1984); 50 Fed.Reg. 35646, 35709 (Sept. 3, 1985).

2. Both parties cited the percentage of actual DRG payments in their briefs, presumably as an agreed-upon proxy for estimated total payments. In FY 1985, actual outlier payments represented only 3.0% of total DRG prospective payments, and in 1986 actual outlier payments were only 4.4% of total DRG prospective payments. Plaintiffs have agreed that the Secretary met her statutory obligation under 42 U.S.C. § 1395ww(d)(5)(A)(iv) for FYs 1984 and 1987.

five to six percent of estimated total Medicare payments for those years. In addition, plaintiffs claim that the manner in which the outlier thresholds were established for FYs 1984 to 1986 was arbitrary and capricious and therefore violated the Administrative Procedure Act. The Secretary, however, adheres to the view that the statute makes no provision for retroactive adjustments to outlier payments if they ultimately diverge from the Secretary's projection, and that her calculation of outlier thresholds was not arbitrary and capricious. *See* Medicare Program; Prospective Payment for Medicare Inpatient Hospital Services, 49 Fed.Reg. 234, 265 (Jan. 3, 1984). As a result, the Secretary refused to award plaintiffs any additional outlier payments. Plaintiffs filed timely appeals of that decision with the Provider Reimbursement Review Board ("PRRB"). The PRRB granted plaintiffs the right to seek expedited judicial review of their claims pursuant to 42 U.S.C. § 1395oo(f). The parties thereafter filed the instant pleadings.

STANDARD OF REVIEW

Summary judgment may be granted only if the pleadings and evidence "show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed.R.Civ.P. 56(c). In considering a summary judgment motion, all evidence and the inferences to be drawn from it must be considered in the light most favorable to the nonmoving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986).

Appendix B

DISCUSSION

I. Proper Interpretation of Section 1395ww(d)(5)(A)(iv)

The first issue in the cross-motions for summary judgment is the proper interpretation of 42 U.S.C. § 1395ww(d)(5)(A)(iv), which, as noted above, provides that "[t]he total amount of the additional payments made . . . for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year." The Secretary argues that this language merely requires her to set outlier thresholds at a level projected to result in outlier payments in the five to six percent range. Plaintiffs claim that the statute requires that actual outlier payments made fall in the range. If the payments do not, plaintiffs contend that the Secretary is required to make retroactive payments to meet the statute's requirement.

This Court's review of the Secretary's interpretation of § 1395ww(d)(5)(A)(iv) is governed by the two-step analysis set out in *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984):

> First . . . is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress. If, however, the court

> determines Congress has not directly addressed the precise question at issue, the court does not simply impose its own construction on the statute. . . . the question for the court is whether the agency's answer is based on a permissible construction of the statute.

Id. at 842-843. The precise question in this case is whether § 1395ww(d)(5)(A)(iv) requires the Secretary to make retroactive adjustments to outlier payments when the total outlier payments for a fiscal year turn out to be less than five percent (or more than six percent) of the total payments estimated to be made for that year.

The starting point in statutory interpretation is the language of the statute itself. *Estate of Cowart v. Nicklos Drilling Co.*, 505 U.S. 469, 475, 112 S.Ct. 2589, 120 L.Ed.2d 379 (1992); *Ardestani v. I.N.S.*, 502 U.S. 129, 135, 112 S.Ct. 515, 116 L.Ed.2d 496 (1991). The plain language of a statute must be read together with its surrounding sections, since "the meaning of statutory language, plain or not, depends on context." *Conroy v. Aniskoff*, 507 U.S. 511, 515, 113 S.Ct. 1562, 123 L.Ed.2d 229 (1993); *see also Davis v. Michigan Dep't of Treas.*, 489 U.S. 803, 809, 109 S.Ct. 1500, 103 L.Ed.2d 891 (1989) ("[W]ords of a statute must be read in their context and with a view to their place in the overall statutory scheme.").

Section 1395ww(d)(5)(A)(iv) states that the "total amount of the additional [outlier] payments made . . . may not be less than 5 percent nor more than 6 percent of the total payment projected or estimated to be made . . . in that

year." The Court finds no ambiguous wording in subsection (iv) that is susceptible to more than one meaning. The statute does not say that the "total amount of payments estimated to be made" must be within the five to six percent range, which is the interpretation proffered by the Secretary. "Projected or estimated" does not modify "total amount of additional payments," it only modifies "total payment" at the end of the subsection. *See id.*

Defendant argues that even though the text of the statute supports plaintiffs' position in isolation, when subsection (iv) is read literally it is inconsistent with its surrounding subsections, leading to ambiguity and absurd results. *See Public Citizen v. United States Dept. of Justice*, 491 U.S. 440, 455, 109 S.Ct. 2558, 105 L.Ed.2d 377 (1989) ("Looking beyond the naked text for guidance is perfectly proper when the result it apparently decrees is difficult to fathom."). Specifically, defendant argues that it is impossible to comply with both §§ 1395ww(d)(5)(A)(iii) and (iv) if the text of subsection (iv) is given its literal meaning.[3]

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3. Subsections 1395ww(d)(5)(A)(i)-(iv) provide, in relevant part:

> (i) . . . [T]he Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceed the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(Cont'd)

The Court cannot agree with defendant's contention. The statute as written does not give rise to inconsistent or absurd results. A natural reading of the related subsections reveals a clear structure pursuant to which the Secretary is supposed to disburse outlier payments. At the beginning of a fiscal year, the Secretary, in her discretion, establishes the "fixed" thresholds, above which a hospital discharge qualifies as an "outlier." *See* 42 U.S.C. § 1395ww(d)(5)(A)(i)-(ii). The Secretary is directed to use the approximate marginal cost of care beyond the threshold as a guideline for the outlier payments she approves during the year. *See id.* at § 1395ww(d)(5)(A)(iii). However, once the total additional payments have been made for the year, the Secretary is instructed to ensure that they are "not . . . less than 5 percent

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(Cont'd)

> (ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges . . . exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater. . . .
>
> (iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall . . . approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).
>
> (iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

nor more than 6 percent of the total payments projected or estimated to be made . . . for discharges in that year." *Id.* at § 1395ww(d)(5)(A)(iv). There is nothing illogical or absurd about initially setting outlier payments at marginal cost and then, when actual outlier data is known, adjusting the final payments to ensure that the Secretary has met her statutory obligation to the providers.

The overall statutory structure fully supports the plain meaning of subsection (iv) and negates any possible ambiguity. *See Estate of Cowart,* 505 U.S. at 477. Subsection (iv) is at the end of the sequence, indicating that it is to be a final limitation on the Secretary's discretion, not an initial step as the Secretary contends. The inconsistency which the Secretary claims exists between subsections (iii) and (iv) is removed by the text of subsection (iii), which requires only that "the amount of such additional payment *under clauses (i) and (ii)* . . . shall . . . approximate the marginal cost of care." *Id.* at § 1395ww(d)(5)(A)(iii) (emphasis added). Subsection (iii) does not say that the final adjustments under subsection (iv) must conform to the marginal cost guidelines.[4]

Moreover, statutes must be read so that "all parts of [the] statute, if possible, are . . . given effect." *Fidelity Federal*

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4. Defendant contends that the word "fixed" in subsections (i) and (ii) means that Congress intended the outlier payments for the year to be "fixed" once made. The statute, however, only states that outlier thresholds must be determined in reference to a fixed number. It does not say that a payment for a discharge beyond that fixed threshold (an outlier) must remain unchanged. *See* 42 U.S.C. § 1395ww(d)(5)(A)(i)-(ii).

Savings and Loan Ass'n v. Cuesta, 458 U.S. 141, 163, 102 S.Ct. 3014, 73 L.Ed.2d 664 (1982) (internal quotation omitted); *see also United States v. Menasche,* 348 U.S. 528, 538-39, 75 S.Ct. 513, 99 L.Ed. 615 (1955); *National Soft Drink Ass'n v. Block,* 721 F.2d 1348, 1352 (D.C.Cir.1983). Plaintiffs' literal reading of the Medicare statute gives effect to every word. Subsection (iii) is given effect as a guideline, and subsection (iv) is given effect as a limitation on the Secretary's discretion. *See* 42 U.S.C. § 1395ww(d)(5)(A)(iii)-(iv). The Secretary's interpretation, on the other hand, ignores Congress' choice of the word "made" as a verb for "total additional payments" and would require the Court to assume Congress meant "estimated total additional payments," in contrast to the actual text of the statute. The only way to give effect to every clause and word of the statute, therefore, is to adopt the plain meaning of the text proposed by plaintiffs.[5]

Finally, defendant argues that the literal language of the statute should be ignored because it conflicts with the

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5. The Court does not dispute that the literal language of the statute, requiring the Secretary to adjust outlier payments retrospectively, would necessitate additional work. It may be unusual that Congress would base the range for outlier payments on "projected or estimated" total Medicare payments for a year, not actual payments. It does not, however, lead to a result "so absurd or illogical that Congress could not have intended it." *Conroy,* 507 U.S. at 516. Congress may have decided to use "projected or estimated" total payments for the year as a range in order to promote certainty, so the Secretary would know, at the beginning of the fiscal year, the maximum amount which she would have to allocate to outlier payments. This is a reasonable policy decision, considering the inherent uncertainty of outliers.

legislative history and purpose of the Medicare prospective payment system. The strong presumption that the plain language of the statute expresses congressional intent is rebutted "only in 'rare and exceptional circumstances' . . . when a contrary legislative intent is clearly expressed." *Ardestani*, 502 U.S. at 135-36 (quoting *Rubin v. United States*, 449 U.S. 424, 430, 101 S.Ct. 698, 66 L.Ed.2d 633 (1981)); *see also Estate of Cowart*, 505 U.S. at 475 ("[W]hen a statute speaks with clarity to an issue judicial inquiry into the statute's meaning, in all but the most extraordinary circumstance, is finished."); *United States v. Ron Pair Enters., Inc.*, 489 U.S. 235, 242, 109 S.Ct. 1026, 103 L.Ed.2d 290 (1989) (plain language only ignored "in the rare cases in which the literal application of a statute will produce a result demonstrably at odds with the intention of the drafters") (internal quotation omitted).

In this case, there is no clear statement in the legislative history indicating Congress intended § 1395ww(d)(5)(A)(iv) to have any meaning other than what it states on its face.[6] Nor is a literal reading of § 1395ww(d)(5)(A)(iv) so contrary

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6. Defendant argues that a Senate report which states that "[t]otal expected payments" under the statutory scheme "will be not less than 5 percent, nor more than 6 percent, of total Medicare payments" provides the legislative intent which somehow should compel the Court to ignore the plain language of the statute. *See* S.Rep.No. 98-23, at 51 (1983), *reprinted in* 1983 U.S.C.C.A.N. 143, 191. The context of the report indicates, however, that the word "expected" was used because the report is discussing the Medicare plan in the future tense. *See id.* This single use of the word "expected," though perhaps fortuitous for defendant, is not sufficient to overcome the plain meaning of the statute. *See Ardestani*, 502 U.S. at 135-36.

to the purpose of the Medicare statute as to allow the Court to ignore the text. The Secretary argues that retroactive adjustments to outlier payments would be inconsistent with the nature of the prospective payment mechanism, which provides a fixed rate for hospital discharges, unaffected by a hospital's practices. Plaintiffs respond that retrospective adjustments of outlier payments are not inconsistent with the statutory scheme because they are, by nature, outside the "prospective" part of the Medicare system.

Defendant relies heavily on our court of appeals' decision in *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225 (D.C.Cir.1994), in her argument that a retroactive adjustment to outlier payments would be at odds with the prospective nature of the Medicare statute. In *Methodist Hospital*, the Secretary realized that a regional wage index used to compute DRG rates had been erroneously calculated for several years, but refused to retrospectively apply the adjusted rate to alter the DRG rates for those years. *Id.* at 1226. Several hospitals appealed that decision, arguing that the Medicare statute required the Secretary to give retroactive effect to wage index corrections. *Id.* The D.C. Circuit upheld the Secretary, noting that Congress had given the Secretary discretion to compute wage indexes and that, due to the prospective nature of the Medicare system, a retrospective adjustment in such a circumstance would "cause a significant, if not debilitating, disruption to the Secretary's administration of the already-complex Medicare program." *Id.* at 1233.

The *Methodist Hospital* decision does not, however, control this case. The Secretary was given total discretion

under the Medicare statute to develop the wage index which was at issue in *Methodist Hospital*. *Id.* at 1230. Section 1395ww(d)(5)(A)(iv), on the other hand, is a limit on the Secretary's discretion in making outlier payments. Moreover, the wage index in *Methodist Hospital* was a component of the DRG rates, meaning that a change in the wage index "could [have] affect[ed] the payment rates applicable for each hospital discharge under PPS that year," severely interfering with the prospective nature of the system. *Methodist Hospital*, 38 F.3d at 1233. In contrast, a retroactive adjustment in this case would only affect outlier payments made in a particular year. It would not affect the core of the prospective payment system, the DRG rates.[7]

The Secretary's argument that retrospective adjustments to outlier payments are inconsistent with the Medicare statute is particularly weak considering the simple fact that outlier payments are an exception to the prospective nature of the Medicare system. Outlier payments were developed to shield hospitals from unusually costly or lengthy hospital discharges which otherwise would warrant just the standard DRG rate. *See* Senate Hearing 98-60, *supra.*, at 50. DRG standard rates are set prospectively so that hospitals "receive

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7. Defendant argues that a retroactive change in actual outlier payments made would affect DRG rates because the outlier thresholds would have to be changed so outlier payments could both fall in the range required by subsection (iv) and approximate marginal cost as required in subsection (iii). As explained previously, this is not what the statute requires. Thus, there is no reason why outlier thresholds would be affected by retrospective outlier payment adjustments, and hence no reason why DRG rates themselves would ever have to be retrospectively adjusted.

advance notice of the rates at which their services will be reimbursed." *Methodist Hospital,* 38 F.3d at 1227. In contrast, outlier payments depend on the severity of the particular case, which cannot be known until the patient is discharged. Indeed, the Secretary has noted that outlier payments are "additional payments . . . in recognition of the existence of certain conditions beyond the scope of . . . PPS." 1984 Ann.Rep., Impact of the Medicare Hospital Prospective Payment System, HCFA Pub. No. 03231, at 2-23 [hereinafter "1984 Ann.Rep."].

This case is far more similar to *Georgetown Univ. Hosp. v. Bowen,* 862 F.2d 323 (D.C.Cir.1988), where our court of appeals allowed retrospective adjustments to payments made to hospitals during the years when the "reasonable cost" system was being replaced by the PPS system. *Georgetown,* 862 F.2d at 323-324. In that case, the Secretary also argued that retrospective adjustments would be inconsistent with the prospective nature of the Medicare system. *Id.* at 327. The D.C. Circuit, however, noted that the Secretary's "prospective" argument was not persuasive because Congress had expressly provided for a phase-in period, during which time the system was not totally prospective. *Id.* Similarly, the Secretary's "prospective" argument does not carry much weight in this case, since "outlier" payments are an exception to the otherwise strict prospective nature of the Medicare system. *See* 1984 Ann.Rep. at 2-23.[8]

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8. Because the language of the statute is unambiguous, the Court need not address the reasonableness of the Secretary's interpretation under the second step of *Chevron* or the statute's legislative history. Those issues are only relevant if the statute is

(Cont'd)

II. The Secretary's Outlier Threshold Calculations and the Administrative Procedure Act

Plaintiffs further contend that the manner in which the outlier thresholds were established for fiscal years 1984 through 1986 violated the Administrative Procedure Act ("APA"). *See* 5 U.S.C. § 701 *et seq.* At Issue is the Secretary's decision to use data from the 1981 MEDPAR file, a database containing patient specific data for a random sample of 20 percent of all Medicare hospital discharges occurring during 1981, to set outlier thresholds for the relevant fiscal years. Plaintiffs contend that the Secretary abused her discretion by using the 1981 MEDPAR data, collected when Medicare used a "reasonable cost" reimbursement method, without taking into account the likelihood that the average length of stay would decrease under the new PPS system. The Secretary claims that her decision to use the unadjusted 1981 MEDPAR data was a reasonable choice between imperfect databases after consideration of all relevant factors, and thus fully within her discretion.

(Cont'd)

not clear on its face. *Chevron*, 467 U.S. at 842-43; *Georgetown*, 862 F.2d at 330 (Mikva, J., concurring). In addition, the Court need not address defendant's claim that Congress has acquiesced in the Secretary's interpretation of the statute, since "where the law is plain, subsequent reenactment does not constitute an adoption of a previous administrative construction." *Brown v. Gardner*, 513 U.S. 115, 121, 115 S.Ct. 552, 130 L.Ed.2d 462 (1994) (quoting *Demarest v. Manspeaker*, 498 U.S. 184, 190, 111 S.Ct. 599, 112 L.Ed.2d 608 (1991)).

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Under the APA, an agency's decision may only be set aside if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A); *see also Motor Vehicle Mfrs. Ass'n v. State Farm Mutual Auto., Ins. Co.*, 463 U.S. 29, 41, 103 S.Ct. 2856, 77 L.Ed.2d 443 (1983). As the Supreme Court has stated:

> Normally, an agency rule [is] arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise.

Motor Vehicle, 463 U.S. at 43. An agency must "examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' " *Id.* (quoting *Burlington Truck Lines v. United States*, 371 U.S. 156, 168, 83 S.Ct. 239, 9 L.Ed.2d 207 (1962)). Though a reviewing court "may not supply a reasoned basis for [an] agency's action that the agency itself has not given," a court may "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." *Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc.*, 419 U.S. 281, 285-86, 95 S.Ct. 438, 42 L.Ed.2d 447 (1974).

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The Secretary's decision to use 1981 MEDPAR data for setting outlier thresholds in FYs 1984 and 1985 meets this "arbitrary and capricious" standard.[9] The administrative record for FY 1984 shows that the Secretary recognized there was a chance that the length of stay might decrease under the new prospective system. 49 Fed.Reg. 234, 304 (Jan. 3, 1984). The Secretary noted, however, that "we cannot model or predict exactly how large these opportunities and future changes may be." *Id.* at 303. As a result, the Secretary still considered the 1981 MEDPAR data to be the "best available data" for the FY 1984 calculations. *Id.* at 260. Although the Secretary never specifically addressed outlier thresholds, the Secretary did state generally that "no adjustments [were made] to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment." *Id.* at 255. Thus, the record demonstrates that the Secretary did not "fail to consider" the possibility of a decrease in length of stay when deciding which data to use for calculating outlier thresholds in FY 1984.[10]

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9. Plaintiffs' challenge to outlier thresholds in FY 1986 is limited to the first seven months of FY 1986, when the FY 1985 thresholds were still in effect. The propriety of the challenged FY 1986 thresholds, therefore, depends entirely on the FY 1985 thresholds, so the Court does not address FY 1986 separately.

10. Plaintiffs further argue that the Secretary's decision to use the 1981 MEDPAR data was not rational because she could have adjusted the data to compensate for a decreased length of stay based

(Cont'd)

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Plaintiffs contend that even if the FY 1984 decision was not arbitrary and capricious, the Secretary's failure to use adjusted data in FY 1985 calculations was improper because at that time the Secretary had access to data concerning approximately 2.5 million Medicare discharges that occurred during the early part of FY 1984 (after PPS became effective). Plaintiffs contend that the FY 1985 outlier thresholds were arbitrary and capricious because: (1) the administrative record from FY 1985 does not mention outlier payments, indicating that the Secretary did not consider the issue at all, and (2) even if she did consider both database options, the Secretary's choice of the 1981 MEDPAR data was irrational.

Though a rule may be invalidated under the APA because an agency fails to explain the rule adequately under the "notice and comment" rulemaking requirements,

> [t]here is no obligation to make references in the agency explanation to all the specific issues raised in comments. The agency's explanation must simply enable a reviewing court to see what major issues of policy were ventilated by the informal proceedings and why the agency reacted to them the way it did.

(Cont'd)

on the results of a New Jersey demonstration using a DRG-based prospective payment system similar to PPS. Such an adjustment, however, could easily have overcompensated for the decrease in the length of stay. Given the narrow scope of review, it cannot be said that the Secretary's decision to choose one imperfect database over another was arbitrary and capricious. *See Mt. Diablo Hosp. v. Shalala*, 3 F.3d 1226, 1233 (9th Cir.1993).

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State of South Carolina ex rel. Tindal v. Block, 717 F.2d 874, 886 (4th Cir.1983) (internal citations omitted), *cert. denied*, 465 U.S. 1080, 104 S.Ct. 1444, 79 L.Ed.2d 764 (1984); *see also United Mine Workers of America, Int'l Union v. Dole*, 870 F.2d 662, 666 (D.C.Cir.1989) (regulatory statements "need not be an exhaustive, detailed account of every aspect of the rulemaking proceedings") (internal quotation omitted); *Mt. Diablo Hosp. v. Shalala*, 3 F.3d 1226, 1234 (9th Cir.1993). The "keystone" inquiry is whether the Secretary "engaged in reasoned decisionmaking." *International Ladies' Garment Workers' Union v. Donovan*, 722 F.2d 795, 815 (D.C.Cir.1983); *Mt. Diablo*, 3 F.3d at 1234. This Court may "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." *Bowman Transp.*, 419 U.S. at 286.

The record before the Court shows that the Secretary did consider the possibility of using the limited FY 1984 data to calculate outlier payments for 1985, but rejected the idea because of concerns about the data's reliability. The declaration of Rose Connerton, an employee of the Department of Health and Human Services who was directly involved in the development of regulatory criteria that governed the computation of outlier payments during FYs 1984 to 1986, explains that the FY 1984 data were "not representative of a full year's set of prospective payment cases both because the fiscal year was not yet concluded and because most hospitals did not become subject to PPS until after the fiscal year began." Connerton Decl. ¶ 15. The Secretary did not rely on the FY 1984 data because the "use of the data would have skewed the resulting outlier calculations by potentially introducing biases based upon

regional hospital practice patterns, the types of hospitals included (particularly the lack of cases treated by teaching hospitals), and seasonal factors (since much of the data related to illnesses treated in the winter months.)"[11] *Id.*

An overview of the entire administrative record supports this description of the Secretary's contemporaneous

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11. Plaintiffs argue that this paragraph, among others in the Connerton declaration, should be stricken from the record as post-hoc rationalizations which may not properly be considered by a reviewing court. Though review of an agency decision pursuant to the APA typically is confined to the administrative record, extra-record evidence may be considered to explain the record in cases involving complex subject matter or to ascertain whether the agency properly considered all relevant factors. *See Citizens To Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 420, 91 S.Ct. 814, 28 L.Ed.2d 136 (1971), *abrogated on other grounds, Califano v. Sanders,* 430 U.S. 99, 97 S.Ct. 980, 51 L.Ed.2d 192 (1977); *AT & T Info. Systems, Inc. v. General Servs. Admin.,* 810 F.2d 1233, 1236 (D.C.Cir.1987) (per curiam); *Environmental Defense Fund, Inc. v. Costle,* 657 F.2d 275, 284-85 (D.C.Cir.1981). Additional background information or evidence about whether all relevant factors were examined by the agency is permissible so long as the additional material does not "offer post-hoc rationalizations where no rationalization exists." *AT & T,* 810 F.2d at 1236. The Medicare statute is certainly complex subject matter, and the Connerton declaration was offered to clarify that the agency did in fact consider all relevant factors in making its decision. *See Methodist Hosp.,* 38 F.3d at 1227. The declaration is "merely explanatory of the original record and . . . contain[s] no new rationalizations." *Costle,* 657 F.2d at 285. In particular, paragraph 15 is not a rationalization made solely for the purposes of litigation, since the same rationale was proffered in 1985 in response to a comment on the record regarding the Secretary's reasons for not recalibrating DRG rates based on post-PPS data. *See* 50 Fed.Reg. 35646, 35654 (Sept. 3, 1985).

reasoning and indicates that the use of pre-PPS data to project outlier payments early in the "prospective payment" era was part of a calculated decision regarding the most reliable data to be used in projections. Before FY 1986, the Secretary was asked on the record about her decision to use pre-PPS data rather than FY 1984 data to calculate the DRG relative weights for FY 1986. The Secretary explained that "the disadvantages of recalibrating using only the prospective payment system bills outweigh the advantages," since the low volume of cases available to make the calculations was likely to skew the projections due to seasonal effects. 50 Fed.Reg. 35646, 35654 (Sept. 3, 1985). Though the rulemaking record from 1984 does not mention the Secretary's reasons for using the 1981 MEDPAR data to calculate outlier thresholds, the entire administrative record and the additional material properly before this Court are sufficient to "reasonably discern[ ]" that the Secretary considered using FY 1984 data, but did not because of concerns about their reliability. *See Bowman Transp.*, 419 U.S. at 286 (reviewing court may "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned"). As such, the Secretary's use of the 1981 MEDPAR data in FY 1985 to set outlier payments was a rational choice between two imperfect databases, and was not arbitrary and capricious.[12] *See Mt. Diablo*, 3 F.3d at 1233.

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12. Plaintiffs argue that the Secretary's rationale is "so implausible that it [can]not be ascribed to a difference in view or the product of agency expertise," because the FY 1984 data were used in 1985 to make other nationwide adjustments. *Motor Vehicle*, 463 U.S. at 43. The fact that the data were sufficiently reliable for nationwide, aggregate adjustments does not mean, however, that

(Cont'd)

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CONCLUSION

The language of 42 U.S.C. § 1395ww(d)(5)(A)(iv) clearly requires that the total outlier payments made in a particular year fall between five and six percent of the total payments projected or estimated to be made for discharges in that year. The Secretary, therefore, violated her statutory duty in years in which the total outlier payments made did not fall within the mandated range and in which she refused to make retroactive payments to comply with the statute. The Secretary did not act in an arbitrary and capricious manner, however, in deciding to use 1981 MEDPAR data to calculate outlier thresholds for fiscal years 1984 through 1986.

For all the foregoing reasons, plaintiffs' motion for summary judgment is granted in part and denied in part, defendant's motion for summary judgment is granted in part and denied in part, and plaintiffs' motion to strike portions of the Rose Connerton declaration is denied.

(Cont'd)
they provided an appropriate database for calculating outlier thresholds. To establish outlier thresholds, the Secretary must compute a standard deviation for each DRG. The Secretary cannot rely on general aggregate information concerning hospital lengths of stay for such a calculation; rather, she must have information relating to the mean length of stay for each DRG. The fact that the Secretary used FY 1984 data for nationwide adjustments does not, therefore, mean that the decision to use 1981 MEDPAR data for outlier thresholds was irrational.

APPENDIX C — JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF COLUMBIA DATED AND FILED APRIL 30, 1998

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Civil Action No. 93-0146 SSH/DAR

COUNTY OF LOS ANGELES,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Civil Action No. 93-0147 SSH/DAR

PASADENA HOSPITAL ASSOCIATES, LTD.,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Appendix C

Civil Action No. 93-0479 SSH/DAR

ROBERT PACKER HOSPITAL AND
CABRINI MEDICAL CENTER,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Civil Action No. 93-0692 SSH/DAR

SUMMIT HOSPITAL CORPORATION,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Civil Action No. 93-0836 SSH/DAR

UNIVERSAL HEALTH SERVICES, INC.,

Plaintiff,

v.

Appendix C

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Civil Action No. 93-0837 SSH/DAR

GALEN MEDICAL CORPORATION, *et al.*,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Civil Action No. 93-1188 SSH/DAR

NU-MED BALDWIN PARK, INC., *et al.*,

Plaintiffs,

v.

DONNA E. SHALALA, Secretary of
Health and Human Services,

Defendant.

Appendix C

Civil Action No. 93-2069 SSH/DAR

CHARTER MEDICAL CORPORATION,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of Health and Human Services,

Defendant.

Civil Action No. 94-1485 SSH/DAR

HOSPITAL CORPORATION OF NORTHWEST, INC., *et al.*,

Plaintiff,

v.

DONNA E. SHALALA, Secretary of Health and Human Services,

Defendant.

JUDGMENT

In accordance with the Opinion and Order entered by this Court in this action on January 20, 1998, it is hereby ORDERED that judgment shall be, and hereby is, entered in

favor of plaintiffs and against defendant with respect to plaintiffs' claim that the Secretary failed to ensure, pursuant to 42 U.S.C. § 1395ww(d)(5)(A)(iv), that actual outlier payments made for federal fiscal years 1985 and 1986 are not less than 5% nor more than 6% of the estimate or projection of total DRG prospective payments for those fiscal years. It is FURTHER ORDERED that judgment shall be, and hereby is, entered in favor of defendant and against plaintiffs with respect to plaintiffs' claim that the outlier thresholds established by the Secretary for federal fiscal years 1984 through 1987 were set in an arbitrary and capricious manner in violation of the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.*.

The Secretary shall compute retroactive adjustments which shall consist of the following:

(a) For each plaintiff hospital that timely sought judicial review pursuant to 42 U.S.C. § 1395oo(f) in these consolidated actions of outlier payments made during a hospital cost reporting period that includes all or any part of federal fiscal year 1985, an additional payment equal to 66.7% of the actual amount of outlier payments made to each plaintiff hospital pursuant to 42 U.S.C. § 1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period falling within federal fiscal year 1985;

(b) For each plaintiff hospital that timely sought judicial review pursuant to 42 U.S.C. § 1395oo(f) in these consolidated actions of outlier payments made during a hospital cost reporting period that includes all or any part of

federal fiscal year 1986, an additional payment equal to 13.6% of the actual amount of outlier payments made to each plaintiff hospital pursuant to 42 U.S.C. § 1395ww(d)(5)(A) for discharges which occurred during the portion of each such hospital cost reporting period falling within federal fiscal year 1986; and

(c) an adjustment to indirect medical education payments made pursuant to 42 U.S.C. § 1395ww(d)(5)(B), and disproportionate share payments made pursuant to 42 U.S.C. § 1395ww(d)(5)(F), based on the additional outlier payments made pursuant to (a) and (b) above.

In lieu of computing the actual amount of outlier payments made for discharges during the periods described in paragraphs (a) and (b) above, the Secretary may compute an estimate of such payments, utilizing such data as may be available. Payment of retroactive adjustments, along with interest as required by 42 U.S.C. § 1395oo(f)(2), shall be made to the plaintiff hospitals in accordance with the parties' Stipulation dated April 20, 1998. The Court shall retain jurisdiction over this case to resolve any disputes between the parties regarding the methodology and data sources to be used for implementation of this Judgment or the calculation of payments due to plaintiffs pursuant to this Judgment.

Dated: APR 30 1998

s/ Stanley S. Harris
UNITED STATES DISTRICT JUDGE

APPENDIX D — ORDERS OF THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT DENYING PETITION FOR REHEARING AND REHEARING EN BANC DATED AND FILED NOVEMBER 30, 1999

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 98-5254

September Term, 1999
93cv00146
93cv00147
93cv00479
93cv00692
93cv00836
93cv00837
93cv01188
93cv02069
94cv01485

County of Los Angeles, a political subdivision of the State of California, owner and operator of Los Angeles County/ USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital,

Appellee

v.

Donna E. Shalala, Secretary, U.S. Department of Health and Human Services,

Appellant

Appendix D

Consolidated with 98-5255, 98-5256, 98-5257, 98-5258, 98-5259, 98-5260, 98-5261, 98-5262, 98-5325, 98-5326, 98-5327, 98-5328, 98-5329, 98-5330, 98-5331, 98-5332, 98-5333

BEFORE: Silberman and Tatel, Circuit Judges

ORDER

Upon consideration of appellees/cross-appellants' petition for rehearing filed November 15, 1999, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

Former Circuit Judge Wald was the third member of this panel.

Appendix D

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 98-5254

September Term, 1999
93cv00146
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County of Los Angeles, a political subdivision of the State of California, owner and operator of Los Angeles County/ USC Medical Center, Harbor/UCLA Medical Center, Martin Luther King Jr./Drew Medical Center, Olive View Medical Center and High Desert Hospital,

Appellee

v.

Donna E. Shalala, Secretary, U.S. Department of Health and Human Services,

Appellant

Appendix D

Consolidated with 98-5255, 98-5256, 98-5257, 98-5258, 98-5259, 98-5260, 98-5261, 98-5262, 98-5325, 98-5326, 98-5327, 98-5328, 98-5329, 98-5330, 98-5331, 98-5332, 98-5333

BEFORE: Edwards, Chief Judge; Silberman, Williams, Ginsburg, Sentelle, Henderson, Randolph, Rogers, Tatel and Garland, Circuit Judges

ORDER

Upon consideration of appellees/cross-appellants' petition for rehearing en banc, and the absence of a request by any member of the court for a vote, it is

ORDERED that the petition be denied.

Per Curiam

FOR THE COURT:
Mark J. Langer, Clerk

BY: s/ Robert A. Bonner
Robert A. Bonner
Deputy Clerk

APPENDIX E — RELEVANT STATUTE

42 U.S.C. § 1395ww

* * *

(d) Inpatient hospital service payments on basis of prospective rates; Medicare Geographic Classification Review Board

* * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payment may be made under part A of this subchapter. Each such rate shall be determined for hospitals located in large urban, other urban, or rural areas within the United States and within each such region, respectively, as follows:

* * *

(B) The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) for hospitals located in an urban area and for hospitals located in a rural area by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this subsection based on DRG prospective payment amounts which are additional payments

described in paragraph (5)(A) (relating to outlier payments) for hospitals located in such respective area.

* * *

(5)(A)(i) The Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater.

(iii) The amount of such additional payment under clauses (i) and (ii) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i) or (ii).

(iv) The total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

* * *

APPENDIX F — PARTIES TO THE PROCEEDING AND CORPORATE DISCLOSURE STATEMENT

A. Parties to the Proceeding

The following are additional petitioners that are not listed in the caption:

Mesa General Hospital Medical Center, Inc., an Arizona corporation, d/b/a Mesa General Hospital Medical Center; Davenport Medical Center, Inc., an Iowa corporation, d/b/a Davenport Medical Center; Santa Ana Hospital Medical Center, Inc., a California corporation, d/b/a Santa Ana Hospital Medical Ctr./Doctors Hospital of Santa Ana; NAI Community Hospital of Phoenix, Inc., an Arizona corporation, d/b/a Community Hospital Medical Center; Whittier Hospital Medical Center, Inc., a California corporation, d/b/a Whittier Hospital Medical Center; Valley Community Hospital, Inc., a California corporation, d/b/a Valley Community Hospital; French Hospital Medical Center, Inc., a California corporation, d/b/a French Hospital Medical Center; Midway Hospital Medical Center, Inc., a California corporation, d/b/a Midway Hospital Medical Center, Nu-Med, Inc., a privately held corporation, Nu-Med Baldwin Park, Inc., a California corporation, d/b/a Terrace Plaza Medical Center, Nu-Med Hospitals, Inc., an Oregon corporation, d/b/a Valley Community Hospital, Nu-Med Hospitals, Inc., a Texas corporation, d/b/a Doctors Hospital, Nu-Med Pembroke, Inc., a Florida corporation, d/b/a Pembroke Pines General Hospital, Nu-Med La Mirada, Inc., a California corporation, d/b/a Medical Center of La Mirada, Nu-Med Sherman Oaks, Inc., a California corporation, d/b/a Sherman Oaks Community Hospital, Nu-Med Studebaker, Inc., a California corporation, d/b/a Coast Plaza

Medical Center, Nu-Med West Park, Inc., a California corporation, d/b/a Nu-Med Regional Medical Center, South Campus, Nu-Med West Park, Inc., a California corporation, d/b/a Nu-Med Regional Medical Center, North Campus, Nu-Med Lake, Inc., a Florida corporation, d/b/a Lake Medical Center, Columbia/HCA, Inc., a publicly held corporation, Galen Medical Corporation, d/b/a Florence Hospital and Medical City — Shoals, Doctors Hospital of Augusta, Inc., d/b/a Augusta Regional Medical Center, Galen of Arizona, Inc., d/b/a Paradise Valley Hospital, Galen of Florida, Inc., d/b/a Dade City Hospital, Daytona Medical Center, Fort Walton Beach Medical Center, Lucerne Medical Center, Orange Park Medical Center, Westside Regional Medical Center, Galen Hospital of Illinois, Inc., d/b/a Michael Reese Hospital and Medical Center and formerly d/b/a Humana Hospital Springfield, Galen of Kansas, Inc., d/b/a Overland Park Regional Medical Center, Western Plains Regional Hospital, Galen of Kentucky, Inc., d/b/a Audubon Regional Medical Center, Suburban Medical Center, Glencare, Inc., d/b/a Brandon Hospital and Destin Hospital, Community Hospital of Palm Beaches, Inc., d/b/a Palm Beaches Medical Center, Galen Hospital Corporation, Inc., d/b/a Clear Lake Regional Medical Center, San Antonio Regional Hospital and formerly d/b/a Humana Hospital Charlotte and Humana Hospital — Southmore, Galen Hospitals of Texas, Inc., d/b/a Brazos Valley Medical Center, Medical City Dallas Hospital and formerly d/b/a Humana Hospital — Baytown, Galen of Tennessee, Inc., formerly d/b/a Humana Hospital-McFarland, General Hospitals of Galen, Inc., d/b/a Cartersville Medical Center, and Peachtree Regional Hospital, Beaumont Hospital, Inc., d/b/a Beaumont Medical Surgical Hospital, Galen of West Virginia, Inc.,

d/b/a Greenbrier Valley Medical Center, Galen Health Care, Inc., d/b/a Aventura Hospital and Medical Center, San Leandro Hospital, Sebastian Hospital, and formerly d/b/a Humana Hospital South Broward and Humana Hospital Sun Bay, Galen of Virginia, Inc., d/b/a University of Louisville Hospital, Galen Virginia Hospital Corporation, formerly d/b/a Humana Hospital-Bayside and Humana Hospital — St. Luke's Richmond, Suburban Medical Center at Hoffman Estates, Inc., d/b/a Hoffman Estates Medical Center, and Sunrise Hospital, d/b/a Sunrise Hospital and Medical Center, Hospital Corporation of Northwest, Inc., an Arizona corporation, d/b/a Northwest Hospital, Medical Center of Santa Rosa, Inc., a Florida corporation, d/b/a Santa Rosa Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a Northwest Regional Hospital, West Paces Ferry Hospital, Inc., a Georgia corporation, d/b/a West Paces Medical Center, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Meadowview Regional Hospital, Hospital Corporation of Utah, a Utah corporation, d/b/a Lakeview Hospital, Lewis-Gale Hospital, Inc., a Virginia corporation, d/b/a Lewis-Gale Hospital, HCA Health Services of Virginia, Inc., a Virginia corporation, d/b/a Reston Hospital Center, Putnam Hospital, Inc., a Florida corporation, d/b/a Putnam Community Hospital, Community Hospital of Andalusia, Inc., an Alabama corporation, d/b/a Andalusia Hospital, Community Hospital of DeQueen, Inc., an Arkansas corporation, d/b/a Community Hospital of DeQueen, HCA Hospital Services of San Diego, Inc., a California corporation, d/b/a Green Hospital of Scripps Clinic, Los Robles Regional Medical Center, a California corporation, d/b/a Los Robles Regional Medical Center, Community Hospital of LaHabra, Inc., a California

corporation, d/b/a LaHabra Community Hospital, Chino Community Hospital Corporation, Inc., a California corporation, d/b/a Chino Community Hospital, Easte Point Hospital, Inc., a Florida corporation, d/b/a East Pointe Hospital, North Okaloosa Medical Center, Inc., a Florida corporation, d/b/a North Okaloosa Medical Center, HCA of Florida, Inc., a Florida corporation, d/b/a Doctors Hospital of Sarasota, New Port Richey Hospital, Inc., a Florida corporation, d/b/a New Port Richey Hospital, Hospital Corporation of Lake Worth, a Florida corporation, d/b/a Doctors Hospital of Lake Worth, Marion Community Hospital, Inc., a Florida corporation, d/b/a Marion Community Hospital, St. Augustine Hospital, Inc., a Florida corporation, d/b/a St. Augustine General Hospital, Bay Hospital, Inc., a Florida corporation, d/b/a Gulf Coast Hospital, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a Bayonet Point/Hudson Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a Medical Center of Port St. Lucie, Dublin Community Hospital, a Georgia corporation, d/b/a Fairview Park Hospital, Coliseum Park Hospital, Inc., a Georgia corporation, d/b/a Coliseum Medical Centers, Redmond Park Hospital, Inc., a Georgia corporation, d/b/a Redmond Regional Medical Center, Medical Center — West, Inc., a Georgia corporation, d/b/a Parkway Medical Center, Columbus Doctors Hospital, Inc., a Georgia corporation, d/b/a Doctors Hospital of Columbus, HCA Health Services of Georgia, Inc., a Georgia corporation, d/b/a Hughston Sports Medicine Hospital, Terre Haute Regional Hospital, Inc., an Indiana corporation, d/b/a Terre Haute Regional Hospital, HCA Health Services of Indiana, Inc., an Indiana corporation, d/b/a North Clark Community Hospital, HCA

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Health Services of Kansas, Inc., a Kansas corporation, d/b/a Wesley Medical Center, Springview Hospital, Inc., a Kentucky corporation, d/b/a Spring View Hospital, Hospital Corporation of Kentucky, Inc., a Kentucky corporation, d/b/a Bourbon General Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Logan Memorial Hospital, Greenview Hospital, Inc., a Kentucky corporation, d/b/a Greenview Hospital, Frankfort Hospital, Inc., a Kentucky corporation, d/b/a King's Daughters Memorial Hospital, HCA Health Services of Mississippi, Inc., a Mississippi corporation, d/b/a Vicksburg Medical Center, St. Peter's Community Hospital, Inc., a Missouri corporation, d/b/a St. Peter's Community Hospital, Hobbs Community Hospital, Inc., a New Mexico corporation, d/b/a Lea Regional Hospital, HCA-Raleigh Community Hospital, Inc., a North Carolina corporation, d/b/a Raleigh Community Hospital, HCA Health Service of North Carolina, Inc, a North Carolina corporation, d/b/a Orthopaedic Hospital of Charlotte, Hospital Corporation of North Carolina, a North Carolina corporation, d/b/a Brunswick Hospital, Walterboro Community Hospital, Inc., a South Carolina corporation, d/b/a Colleton Regional Hospital, North Trident Regional Hospital, Inc., a South Carolina corporation, d/b/a Trident Regional Medical Center, Hospital Corporation of Tennessee, a Tennessee corporation, d/b/a Volunteer General Hospital, Athens Community Hospital, Inc., a Tennessee corporation, d/b/a Athens Community Hospital, Medical Park Hospital, Inc., a Tennessee corporation, d/b/a North Park Hospital, Benton Community Hospital, Inc., a Tennessee corporation, d/b/a Benton Community Hospital, Hospital Corporation of America, a Tennessee corporation, d/b/a Park View Medical Center, Hospital Corporation of

America, a Tennessee corporation, d/b/a West Side Hospital, General Care Corp., a Tennessee corporation, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a North Hills Medical Center, DeTar Hospital, Inc., a Texas corporation, d/b/a DeTar Hospital, Wysong Medical Center, Inc., a Texas corporation, d/b/a Wysong Medical Center, Vista Hills Medical Center, Inc., a Texas corporation, d/b/a Vista Hills Medical Center, HCA-Arlington, Inc., a Texas corporation, d/b/a Arlington Medical Center, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a South Austin Medical Center, Midway Park Medical Center Corporation, a Texas corporation, d/b/a Midway Park Medical Center, Northern Virginia Hospital Corporation, a Virginia corporation, d/b/a Northern Virginia Doctors Hospital, Pulaski Community Hospital, Inc., a Virginia corporation, d/b/a Pulaski Community Hospital, Raleigh General Hospital, a West Virginia corporation, d/b/a Raleigh General Hospital, Teays Valley Health Services, Inc., a West Virginia corporation, d/b/a Putnam General Hospital, Wyoming Health Services, Inc., a Wyoming corporation, d/b/a Riverton Memorial Hospital, Tallahassee Medical Center, Inc., a Florida corporation, d/b/a Tallahassee Community Hospital, Largo Medical Center, Inc., an Florida corporation, d/b/a Largo Medical Center, Hartselle Medical Center, Inc., an Alabama corporation, d/b/a Hartselle Medical Center, The L.V. Stabler Memorial Hospital of Greenville, Inc., a Alabama corporation, d/b/a L.V. Stabler Memorial Hospital, Encino Hospital Corporation, Inc., a California corporation, d/b/a Encino Hospital, Sabastopol Hospital Corporation, a California corporation, d/b/a Palm Drive Hospital, Ukiah Hospital Corporation,a California corporation, d/b/a Ukiah General Hospital, Okaloosa Hospital, Inc., a Florida

corporation, d/b/a Twin Cities Hospital, North Beach Hospital, Inc., a Florida corporation, d/b/a North Beach Hospital, Central Florida Regional Hospital, Inc., a Florida corporation, d/b/a Central Florida Regional Hospital, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a North Florida Regional Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a L.W. Blake Hospital, Tamarac Hospital Corporation, Inc., a Florida corporation, d/b/a University Hospital, West Florida Regional Medical Center, Inc., a Florida corporation, d/b/a West Florida Regional Medical Center, General Health Services, Inc., a Florida corporation, d/b/a Edward H. White Hospital, Lawnwood Medical Center, Inc., a Florida corporation, d/b/a Lawnwood Regional Medical Center, Okeechobee Hospital, Inc., a Florida corporation, d/b/a Raulerson Hospital, HCA Health Services of Georgia, Inc., a Georgia corporation, d/b/a Northlake Regional Medical Center, Clayton Acquisition Corp., a Georgia corporation, d/b/a Ridgecrest Hospital, Hospital Corporation of Lanier, Inc., a Georgia corporation, d/b/a Lanier Park Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Scott General Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Valley View Medical Center, formerly known as Union County Methodist Hospital, Dauterive Hospital Corporation, a Kentucky corporation, d/b/a Dauterive Hospital, HCA Health Services of Louisiana, Inc., a Louisiana corporation, d/b/a North Monroe Hospital, Guadalupe Medical Center, Inc., a New Mexico corporation, d/b/a Guadalupe Medical Center, HCA-Raleigh Community Hospital, Inc., a North Carolina corporation, d/b/a Raleigh Community Hospital, Cumberland Medical Center, Inc., a North Carolina corporation, d/b/a

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Highsmith-Rainey Memorial Hospital, HCA Health Services of Oklahoma, Inc., an Oklahoma corporation, d/b/a Presbyterian Hospital, Edmond Memorial Hospital, Inc., an Oklahoma corporation, d/b/a Edmond Memorial Hospital, McMinnville Hospital, Inc., an Oregon corporation, d/b/a McMinnville Community Hospital, SP Acquisition Corp., a Tennessee corporation, d/b/a South Pittsburg Municipal Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Smyrna Medical Center, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Donelson Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Diagnostic Hospital, Indian Path Hospital, Inc., a Tennessee corporation, d/b/a Indian Path Hospital, Bradley Community Hospital, Inc., a Tennessee corporation, d/b/a Cleveland Community Hospital, Hospital Corporation of White County, a Tennessee corporation, d/b/a White County Community Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Southern Hills Medical Center, Navarro Memorial Hospital, Inc., a Texas corporation, d/b/a Navarro Regional Hospital, Woodland Heights General Hospital, Inc., a Texas corporation, d/b/a Woodland Heights Medical Center, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a Spring Branch Medical Center, Doctors Hospital Conroe, Inc., a Texas corporation, d/b/a Doctors Hospital of Conroe, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a West Houston Medical Center, HSP of Texas, Inc., a Texas corporation, d/b/a Medical Center of Plano, Malone-Hogan Hospital, Inc., a Texas corporation, d/b/a Malone-Hogan Hospital, Brownsville — Valley Regional Medical Center, Inc., a Texas corporation, d/b/a Valley Regional Medical Center, Forth Worth Medical Plaza, Inc.,

a Texas corporation, d/b/a Medical Plaza Hospital, Longview Regional Hospital, Inc., a Texas corporation, d/b/a Longview Regional Hospital, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a Rio Grande Regional Hospital, HCA of Utah, Inc., a Utah corporation, d/b/a Ashley Valley Medical Center, Olympia Hospital Corporation, a Washington corporation, d/b/a Black Hills Community Hospital, Tri Cities Health Services Corp., a West Virginia corporation, d/b/a River Park Hospital, Magellan Health Services, Inc., a publicly held corporation, Charter Medical Corporation, doing business through its wholly-owned subsidiaries as: Charter Medical-Cleveland, Inc., a Texas corporation, d/b/a Charter Community Hospital/Cleveland , Charter Community Hospital of Des Moines, Inc., an Iowa corporation, d/b/a Charter Community Hospital/Des Moines, Desert Springs Hospital, Inc., a Nevada corporation, d/b/a Desert Springs Hospital, Charter Community Hospital, Inc., a California corporation, d/b/a Charter Community Hospital/ Hawaiian Gardens, Middle Georgia Hospital, Inc., a Georgia corporation, d/b/a Middle Georgia Hospital, Charter Northside Hospital, Inc., a Georgia corporation, d/b/a Charter Northside Hospital, Physicians & Surgeons Hospital, Inc., a Louisiana corporation, d/b/a Physicians & Surgeons Hospital, Charter Suburban Hospital of Mesquite, Inc., a Texas corporation, d/b/a Charter Suburban Hospital/ Mesquite, and Charter Suburban Hospital, Inc., a California corporation, d/b/a Charter Suburban Hospital/Paramount, Universal Health Services, Inc., a publicly held corporation, UHS of Auburn, Inc., a Washington corporation, d/b/a Auburn General Hospital, UHS of Belmont, Inc., an Illinois corporation, d/b/a Belmont Community Hospital, Chalmette General Hospital, Inc., a Louisiana corporation, d/b/a

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Chalmette Medical Centers, Dallas Family Hospital, Inc., a Texas corporation, d/b/a Dallas Family Hospital, Doctors Hospital of Hollywood, Inc., a Florida corporation, d/b/a Doctors' Hospital of Hollywood, UHS of Shreveport, Inc., a Louisiana corporation, d/b/a Doctors' Hospital of Shreveport, Universal Health Services of Inland Valley, Inc., a California corporation, d/b/a Inland Valley Regional Medical Center, McAllen Medical Center, Inc., a Texas corporation, d/b/a McAllen Medical Center, Panorama Community Hospital, Inc., a Delaware corporation, d/b/a Panorama Community Hospital, UHS of River Parishes, Inc., a Louisiana corporation, d/b/a River Parishes Medical Center, Universal Health Svs. of Nevada, Inc., a Nevada corporation, d/b/a Valley Hospital Medical Center, Victoria Regional Medical Center, Inc., a Texas corporation, d/b/a Victoria Regional Medical Center Gulf Coast Regional Heart Institute, Wellington Regional Medical Center, Incorporated, a Florida corporation, d/b/a Wellington Regional Medical Ctr., Westlake Medical Center, Inc., a California corporation, d/b/a Westlake Medical Center, and formerly doing business through its wholly-owned subsidiaries as: UHS of Centralia, Inc. d/b/a Centralia General Hospital, UHS of Bethesda, Inc. d/b/a Mount Sinai Hospital, UHS of Riverton, Inc. d/b/a Riverton General Hospital, and Oak Cliff Medical and Surgical Hospital, Inc. d/b/a Southwest Dallas Hospital, Sparks Reno Partnership, L.P., a Delaware limited partnership, wherein Universal Health Services, Inc. is the general partner, d/b/a Sparks Family Hospital; and Doctors General Hospital, Ltd., a Florida limited partnership, wherein Universal Health Services, Inc. is the general partner, d/b/a Universal Medical Center, Pasadena Hospital Associates, Ltd., a nonprofit public benefit corporation, d/b/a/

Huntington Memorial Hospital, Covenant Health, Cabrini Medical Center, a nonprofit, tax-exempt entity sponsored by the Missionary Sisters of the Sacred Heart, a nonprofit, tax-exempt organization, and Robert Packer Hospital, a nonprofit, tax-exempt corporation whose parent is the Guthrie Healthcare System, a nonprofit, tax-exempt corporation.

B. Corporate Disclosure Statement

The following is a list of the corporations with a financial interest in the outcome of this petition:

Cabrini Medical Center, a nonprofit, tax-exempt organization sponsored by the Missionary Sisters of the Sacred Heart, a nonprofit, tax-exempt organization, either owns or retains the right to reimbursement for the fiscal years at issue for the following party: Cabrini Medical Center.

Columbia/HCA, Inc., a publicly held corporation, either owns or retains the right to reimbursement for the fiscal years at issue for the following parties: Galen Medical Corporation, d/b/a Florence Hospital and Medical City — Shoals, Doctors Hospital of Augusta, Inc., d/b/a Augusta Regional Medical Center, Galen of Arizona, Inc., d/b/a Paradise Valley Hospital, Galen of Florida, Inc., d/b/a Dade City Hospital, Daytona Medical Center, Fort Walton Beach Medical Center, Lucerne Medical Center, Orange Park Medical Center, Westside Regional Medical Center, Galen Hospital of Illinois, Inc., d/b/a Michael Reese Hospital and Medical Center and formerly d/b/a Humana Hospital Springfield, Galen of Kansas, Inc., d/b/a Overland Park Regional Medical

Center, Western Plains Regional Hospital, Galen of Kentucky, Inc., d/b/a Audubon Regional Medical Center, Suburban Medical Center, Glencare, Inc., d/b/a Brandon Hospital and Destin Hospital, Community Hospital of Palm Beaches, Inc., d/b/a Palm Beaches Medical Center, Galen Hospital Corporation, Inc., d/b/a Clear Lake Regional Medical Center, San Antonio Regional Hospital and formerly d/b/a Humana Hospital Charlotte and Humana Hospital — Southmore, Galen Hospitals of Texas, Inc., d/b/a Brazos Valley Medical Center, Medical City Dallas Hospital and formerly d/b/a Humana Hospital — Baytown, Galen of Tennessee, Inc., formerly d/b/a Humana Hospital-McFarland, General Hospitals of Galen, Inc., d/b/a Cartersville Medical Center, and Peachtree Regional Hospital, Beaumont Hospital, Inc., d/b/a Beaumont Medical Surgical Hospital, Galen of West Virginia, Inc., d/b/a Greenbrier Valley Medical Center, Galen Health Care, Inc., d/b/a Aventura Hospital and Medical Center, San Leandro Hospital, Sebastian Hospital, and formerly d/b/a Humana Hospital South Broward and Humana Hospital Sun Bay, Galen of Virginia, Inc., d/b/a University of Louisville Hospital, Galen Virginia Hospital Corporation, formerly d/b/a Humana Hospital-Bayside and Humana Hospital — St. Luke's Richmond, Suburban Medical Center at Hoffman Estates, Inc., d/b/a Hoffman Estates Medical Center, and Sunrise Hospital, d/b/a Sunrise Hospital and Medical Center, Hospital Corporation of Northwest, Inc., an Arizona corporation, d/b/a Northwest Hospital, Medical Center of Santa Rosa, Inc., a Florida corporation, d/b/a Santa Rosa Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a Northwest Regional Hospital, West Paces Ferry Hospital, Inc., a Georgia corporation,

d/b/a West Paces Medical Center, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Meadowview Regional Hospital, Hospital Corporation of Utah, a Utah corporation, d/b/a Lakeview Hospital, Lewis-Gale Hospital, Inc., a Virginia corporation, d/b/a Lewis-Gale Hospital, HCA Health Services of Virginia, Inc., a Virginia corporation, d/b/a Reston Hospital Center, Putnam Hospital, Inc., a Florida corporation, d/b/a Putnam Community Hospital, Community Hospital of Andalusia, Inc., an Alabama corporation, d/b/a Andalusia Hospital, Community Hospital of DeQueen, Inc., an Arkansas corporation, d/b/a Community Hospital of DeQueen, HCA Hospital Services of San Diego, Inc., a California corporation, d/b/a Green Hospital of Scripps Clinic, Los Robles Regional Medical Center, a California corporation, d/b/a Los Robles Regional Medical Center, Community Hospital of LaHabra, Inc., a California corporation, d/b/a LaHabra Community Hospital, Chino Community Hospital Corporation, Inc., a California corporation, d/b/a Chino Community Hospital, Easte Point Hospital, Inc., a Florida corporation, d/b/a East Pointe Hospital, North Okaloosa Medical Center, Inc., a Florida corporation, d/b/a North Okaloosa Medical Center, HCA of Florida, Inc., a Florida corporation, d/b/a Doctors Hospital of Sarasota, New Port Richey Hospital, Inc., a Florida corporation, d/b/a New Port Richey Hospital, Hospital Corporation of Lake Worth, a Florida corporation, d/b/a Doctors Hospital of Lake Worth, Marion Community Hospital, Inc., a Florida corporation, d/b/a Marion Community Hospital, St. Augustine Hospital, Inc., a Florida corporation, d/b/a St. Augustine General Hospital, Bay Hospital, Inc., a Florida corporation, d/b/a Gulf Coast Hospital, HCA Health Services of Florida, Inc., a Florida

corporation, d/b/a Bayonet Point/Hudson Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a Medical Center of Port St. Lucie, Dublin Community Hospital, a Georgia corporation, d/b/a Fairview Park Hospital, Coliseum Park Hospital, Inc., a Georgia corporation, d/b/a Coliseum Medical Centers, Redmond Park Hospital, Inc., a Georgia corporation, d/b/a Redmond Regional Medical Center, Medical Center — West, Inc., a Georgia corporation, d/b/a Parkway Medical Center, Columbus Doctors Hospital, Inc., a Georgia corporation, d/b/a Doctors Hospital of Columbus, HCA Health Services of Georgia, Inc., a Georgia corporation, d/b/a Hughston Sports Medicine Hospital, Terre Haute Regional Hospital, Inc., an Indiana corporation, d/b/a Terre Haute Regional Hospital, HCA Health Services of Indiana, Inc., an Indiana corporation, d/b/a North Clark Community Hospital, HCA Health Services of Kansas, Inc., a Kansas corporation, d/b/a Wesley Medical Center, Springview Hospital, Inc., a Kentucky corporation, d/b/a Spring View Hospital, Hospital Corporation of Kentucky, Inc., a Kentucky corporation, d/b/a Bourbon General Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Logan Memorial Hospital, Greenview Hospital, Inc., a Kentucky corporation, d/b/a Greenview Hospital, Frankfort Hospital, Inc., a Kentucky corporation, d/b/a King's Daughters Memorial Hospital, HCA Health Services of Mississippi, Inc., a Mississippi corporation, d/b/a Vicksburg Medical Center, St. Peter's Community Hospital, Inc., a Missouri corporation, d/b/a St. Peter's Community Hospital, Hobbs Community Hospital, Inc., a New Mexico corporation, d/b/a Lea Regional Hospital, HCA-Raleigh Community Hospital, Inc., a North Carolina corporation, d/b/a Raleigh Community Hospital,

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HCA Health Service of North Carolina, Inc, a North Carolina corporation, d/b/a Orthopaedic Hospital of Charlotte, Hospital Corporation of North Carolina, a North Carolina corporation, d/b/a Brunswick Hospital, Walterboro Community Hospital, Inc., a South Carolina corporation, d/b/a Colleton Regional Hospital, North Trident Regional Hospital, Inc., a South Carolina corporation, d/b/a Trident Regional Medical Center, Hospital Corporation of Tennessee, a Tennessee corporation, d/b/a Volunteer General Hospital, Athens Community Hospital, Inc., a Tennessee corporation, d/b/a Athens Community Hospital, Medical Park Hospital, Inc., a Tennessee corporation, d/b/a North Park Hospital, Benton Community Hospital, Inc., a Tennessee corporation, d/b/a Benton Community Hospital, Hospital Corporation of America, a Tennessee corporation, d/b/a Park View Medical Center, Hospital Corporation of America, a Tennessee corporation, d/b/a West Side Hospital, General Care Corp., a Tennessee corporation, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a North Hills Medical Center, DeTar Hospital, Inc., a Texas corporation, d/b/a DeTar Hospital, Wysong Medical Center, Inc., a Texas corporation, d/b/a Wysong Medical Center, Vista Hills Medical Center, Inc., a Texas corporation, d/b/a Vista Hills Medical Center, HCA-Arlington, Inc., a Texas corporation, d/b/a Arlington Medical Center, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a South Austin Medical Center, Midway Park Medical Center Corporation, a Texas corporation, d/b/a Midway Park Medical Center, Northern Virginia Hospital Corporation, a Virginia corporation, d/b/a Northern Virginia Doctors Hospital, Pulaski Community Hospital, Inc., a Virginia corporation, d/b/a Pulaski Community Hospital, Raleigh General Hospital, a West

Virginia corporation, d/b/a Raleigh General Hospital, Teays Valley Health Services, Inc., a West Virginia corporation, d/b/a Putnam General Hospital, Wyoming Health Services, Inc., a Wyoming corporation, d/b/a Riverton Memorial Hospital, Tallahassee Medical Center, Inc., a Florida corporation, d/b/a Tallahassee Community Hospital, Largo Medical Center, Inc., an Florida corporation, d/b/a Largo Medical Center, Hartselle Medical Center, Inc., an Alabama corporation, d/b/a Hartselle Medical Center, The L.V. Stabler Memorial Hospital of Greenville, Inc., a Alabama corporation, d/b/a L.V. Stabler Memorial Hospital, Encino Hospital Corporation, Inc., a California corporation, d/b/a Encino Hospital, Sabastopol Hospital Corporation, a California corporation, d/b/a Palm Drive Hospital, Ukiah Hospital Corporation, a California corporation, d/b/a Ukiah General Hospital, Okaloosa Hospital, Inc., a Florida corporation, d/b/a Twin Cities Hospital, North Beach Hospital, Inc., a Florida corporation, d/b/a North Beach Hospital, Central Florida Regional Hospital, Inc., a Florida corporation, d/b/a Central Florida Regional Hospital, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a North Florida Regional Medical Center, HCA Health Services of Florida, Inc., a Florida corporation, d/b/a L.W. Blake Hospital, Tamarac Hospital Corporation, Inc., a Florida corporation, d/b/a University Hospital, West Florida Regional Medical Center, Inc., a Florida corporation, d/b/a West Florida Regional Medical Center, General Health Services, Inc., a Florida corporation, d/b/a Edward H. White Hospital, Lawnwood Medical Center, Inc., a Florida corporation, d/b/a Lawnwood Regional Medical Center, Okeechobee Hospital, Inc., a Florida corporation, d/b/a Raulerson Hospital, HCA Health Services of Georgia, Inc.,

a Georgia corporation, d/b/a Northlake Regional Medical Center, Clayton Acquisition Corp., a Georgia corporation, d/b/a Ridgecrest Hospital, Hospital Corporation of Lanier, Inc., a Georgia corporation, d/b/a Lanier Park Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Scott General Hospital, Hospital Corporation of Kentucky, a Kentucky corporation, d/b/a Valley View Medical Center, formerly known as Union County Methodist Hospital, Dauterive Hospital Corporation, a Kentucky corporation, d/b/a Dauterive Hospital, HCA Health Services of Louisiana, Inc., a Louisiana corporation, d/b/a North Monroe Hospital, Guadalupe Medical Center, Inc., a New Mexico corporation, d/b/a Guadalupe Medical Center, HCA-Raleigh Community Hospital, Inc., a North Carolina corporation, d/b/a Raleigh Community Hospital, Cumberland Medical Center, Inc., a North Carolina corporation, d/b/a Highsmith-Rainey Memorial Hospital, HCA Health Services of Oklahoma, Inc., an Oklahoma corporation, d/b/a Presbyterian Hospital, Edmond Memorial Hospital, Inc., an Oklahoma corporation, d/b/a Edmond Memorial Hospital, McMinnville Hospital, Inc., an Oregon corporation, d/b/a McMinnville Community Hospital, SP Acquisition Corp., a Tennessee corporation, d/b/a South Pittsburg Municipal Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Smyrna Medical Center, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Donelson Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Diagnostic Hospital, Indian Path Hospital, Inc., a Tennessee corporation, d/b/a Indian Path Hospital, Bradley Community Hospital, Inc., a Tennessee corporation, d/b/a Cleveland Community Hospital, Hospital Corporation of White County, a Tennessee

corporation, d/b/a White County Community Hospital, HCA Health Services of Tennessee, Inc., a Tennessee corporation, d/b/a Southern Hills Medical Center, Navarro Memorial Hospital, Inc., a Texas corporation, d/b/a Navarro Regional Hospital, Woodland Heights General Hospital, Inc., a Texas corporation, d/b/a Woodland Heights Medical Center, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a Spring Branch Medical Center, Doctors Hospital Conroe, Inc., a Texas corporation, d/b/a Doctors Hospital of Conroe, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a West Houston Medical Center, HSP of Texas, Inc., a Texas corporation, d/b/a Medical Center of Plano, Malone-Hogan Hospital, Inc., a Texas corporation, d/b/a Malone-Hogan Hospital, Brownsville — Valley Regional Medical Center, Inc., a Texas corporation, d/b/a Valley Regional Medical Center, Forth Worth Medical Plaza, Inc., a Texas corporation, d/b/a Medical Plaza Hospital, Longview Regional Hospital, Inc., a Texas corporation, d/b/a Longview Regional Hospital, HCA Health Services of Texas, Inc., a Texas corporation, d/b/a Rio Grande Regional Hospital, HCA of Utah, Inc., a Utah corporation, d/b/a Ashley Valley Medical Center, Olympia Hospital Corporation, a Washington corporation, d/b/a Black Hills Community Hospital, Tri Cities Health Services Corp., a West Virginia corporation, d/b/a River Park Hospital. Columbia/HCA, Inc., has no parent company, and no publicly held company owns 10% or more of Columbia/HCA's stock.

Covenant Health, a nonprofit, tax exempt organization either owns or retains the right to reimbursement for the fiscal years at issue for the following party: Park West Hospital.

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Magellan Health Services, Inc., a publicly held corporation, either owns or retains the right to reimbursement for the fiscal years at issue for the following parties: Charter Medical Corporation, doing business through its wholly-owned subsidiaries as: Charter Medical-Cleveland, Inc., a Texas corporation, d/b/a Charter Community Hospital/Cleveland , Charter Community Hospital of Des Moines, Inc., an Iowa corporation, d/b/a Charter Community Hospital/Des Moines, Desert Springs Hospital, Inc., a Nevada corporation, d/b/a Desert Springs Hospital, Charter Community Hospital, Inc., a California corporation, d/b/a Charter Community Hospital/ Hawaiian Gardens, Middle Georgia Hospital, Inc., a Georgia corporation, d/b/a Middle Georgia Hospital, Charter Northside Hospital, Inc., a Georgia corporation, d/b/a Charter Northside Hospital, Physicians & Surgeons Hospital, Inc., a Louisiana corporation, d/b/a Physicians & Surgeons Hospital, Charter Suburban Hospital of Mesquite, Inc., a Texas corporation, d/b/a Charter Suburban Hospital/ Mesquite, and Charter Suburban Hospital, Inc., a California corporation, d/b/a Charter Suburban Hospital/Paramount. Magellan Health Services, Inc., has no parent company, and no publicly held company owns 10% or more of Magellan's stock.

Nu-Med, Inc., a privately held corporation, either owns or retains the right to reimbursement for the fiscal years at issue for the following parties: Nu-Med Baldwin Park, Inc., a California corporation, d/b/a Terrace Plaza Medical Center, Nu-Med Hospitals, Inc., an Oregon corporation, d/b/a Valley Community Hospital, Nu-Med Hospitals, Inc., a Texas corporation, d/b/a Doctors Hospital, Nu-Med Pembroke, Inc., a Florida corporation, d/b/a Pembroke Pines General

Hospital, Nu-Med La Mirada, Inc., a California corporation, d/b/a Medical Center of La Mirada, Nu-Med Sherman Oaks, Inc., a California corporation, d/b/a Sherman Oaks Community Hospital, Nu-Med Studebaker, Inc., a California corporation, d/b/a Coast Plaza Medical Center, Nu-Med West Park, Inc., a California corporation, d/b/a Nu-Med Regional Medical Center, South Campus, Nu-Med West Park, Inc., a California corporation, d/b/a Nu-Med Regional Medical Center, North Campus, Nu-Med Lake, Inc., a Florida corporation, d/b/a Lake Medical Center. Nu-Med, Inc., has no parent company, and no publicly held company owns 10% or more of Nu-Med's stock.

Pasadena Hospital Associates, Ltd., a nonprofit public benefit corporation, d/b/a/ Huntington Memorial Hospital either owns or retains the right to reimbursement for the fiscal years at issue for the following parties: Huntington Memorial Hospital.

Robert Packer Hospital, a nonprofit, tax-exempt corporation whose parent is the Guthrie Healthcare System, a nonprofit, tax-exempt corporation, either owns or retains the right to reimbursement for the fiscal years at issue for the following party: Robert Packer Hospital. In addition, the Health Care Facilities Authority of Sayre, Pennsylvania has issued publicly traded bonds on behalf of Robert Packer Hospital and the Guthrie Healthcare System, as well as for the Tioga Nursing Facility, a nonprofit, tax-exempt corporation, which is affiliated with Robert Packer Hospital.

Tenet Healthcare Corporation, a publicly held corporation, either owns or retains the right to reimbursement for the fiscal

years at issue for the following parties: Mesa General Hospital Medical Center, Inc., an Arizona corporation, d/b/a Mesa General Hospital Medical Center; Davenport Medical Center, Inc., an Iowa corporation, d/b/a Davenport Medical Center; Santa Ana Hospital Medical Center, Inc., a California corporation, d/b/a Santa Ana Hospital Medical Ctr/Doctors Hospital of Santa Ana; NAI Community Hospital of Phoenix, Inc., an Arizona corporation, d/b/a Community Hospital Medical Center; Whittier Hospital Medical Center, Inc., a California corporation, d/b/a Whittier Hospital Medical Center; Valley Community Hospital, Inc., a California corporation, d/b/a Valley Community Hospital; French Hospital Medical Center, Inc., a California corporation, d/b/a French Hospital Medical Center; Midway Hospital Medical Center, Inc., a California corporation, d/b/a Midway Hospital Medical Center. Tenet Healthcare Corporation has no parent company, and no publicly held company owns 10% or more of Tenet's stock.

Universal Health Services, Inc., a publicly held corporation, either owns or retains the right to reimbursement for the fiscal years at issue for the following parties: UHS of Auburn, Inc., a Washington corporation, d/b/a Auburn General Hospital, UHS of Belmont, Inc., an Illinois corporation, d/b/a Belmont Community Hospital, Chalmette General Hospital, Inc., a Louisiana corporation, d/b/a Chalmette Medical Centers, Dallas Family Hospital, Inc., a Texas corporation, d/b/a Dallas Family Hospital, Doctors Hospital of Hollywood, Inc., a Florida corporation, d/b/a Doctors' Hospital of Hollywood, UHS of Shreveport, Inc., a Louisiana corporation, d/b/a Doctors' Hospital of Shreveport, Universal Health Services of Inland Valley, Inc., a California corporation, d/b/a Inland

Appendix F

Valley Regional Medical Center, McAllen Medical Center, Inc., a Texas corporation, d/b/a McAllen Medical Center, Panorama Community Hospital, Inc., a Delaware corporation, d/b/a Panorama Community Hospital, UHS of River Parishes, Inc., a Louisiana corporation, d/b/a River Parishes Medical Center, Universal Health Svs. of Nevada, Inc., a Nevada corporation, d/b/a Valley Hospital Medical Center, Victoria Regional Medical Center, Inc., a Texas corporation, d/b/a Victoria Regional Medical Center Gulf Coast Regional Heart Institute, Wellington Regional Medical Center, Incorporated, a Florida corporation, d/b/a Wellington Regional Medical Ctr., Westlake Medical Center, Inc., a California corporation, d/b/a Westlake Medical Center, and formerly doing business through its wholly-owned subsidiaries as: UHS of Centralia, Inc. d/b/a Centralia General Hospital, UHS of Bethesda, Inc. d/b/a Mount Sinai Hospital, UHS of Riverton, Inc. d/b/a Riverton General Hospital, and Oak Cliff Medical and Surgical Hospital, Inc. d/b/a Southwest Dallas Hospital, Sparks Reno Partnership, L.P., a Delaware limited partnership, wherein Universal Health Services, Inc. is the general partner, d/b/a Sparks Family Hospital; and Doctors General Hospital, Ltd., a Florida limited partnership, wherein Universal Health Services, Inc. is the general partner, d/b/a Universal Medical Center. Universal Health Services, Inc., has no parent company, and no publicly held company owns 10% or more of Universal Health Service's stock.

Supreme Court, U.S.
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No. 99-1421

In the Supreme Court of the United States

COUNTY OF LOS ANGELES, ET AL., PETITIONERS

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

For the years in question, the Medicare Act permitted additional payments to hospitals for "outlier" cases, *i.e.*, those that involve an extraordinarily costly or lengthy period of hospitalization when compared to most discharges in the same diagnosis-related group. Section 1395ww(d)(5)(A)(iv) of Title 42, U.S.C., provides that "[t]he total amount of the additional payments made under this subparagraph [for outlier cases] for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year."

The question presented is whether the court of appeals correctly upheld the Secretary's interpretation that Section 1395ww(d)(5)(A)(iv) does not require her to make retroactive adjustments to payments to hospitals for services they provide in outlier cases when aggregate payments nationwide for such cases are less than the total that she projected at the beginning of the fiscal year.

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In the Supreme Court of the United States

No. 99-1421

COUNTY OF LOS ANGELES, ET AL., PETITIONERS

v.

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-39a) is reported at 192 F.3d 1005. The opinion of the district court (Pet. App. 40a-64a) is reported at 992 F. Supp. 26.

JURISDICTION

The judgment of the court of appeals (Pet. App. 65a-70a) was entered on October 1, 1999. Petitions for rehearing were denied on November 30, 1999 (Pet. App. 71a-74a). The petition for a writ of certiorari was filed on February 28, 2000. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Title XVIII of the Social Security Act, 42 U.S.C. 1395-1395ggg (1994 & Supp. III 1997) (Medicare Act), establishes the federally funded Medicare program to provide health insurance to the elderly and disabled. From its inception in 1965 until 1983, the Medicare Act compensated hospitals for the "reasonable cost" or "customary charges" of inpatient services they provided to eligible patients. See 42 U.S.C. 1395f(b) (1994 & Supp. III 1997). Since 1983, Medicare has reimbursed most hospitals for the inpatient costs under the Prospective Payment System (PPS), which generally directs that payments to hospitals be based upon prospectively determined rates for each inpatient discharge.

Prospective payment rates are derived under a statutory formula. 42 U.S.C. 1395ww(d). To set the initial prospective payment rates (for federal fiscal year 1984), the Secretary calculated standard federal rates (known as "standardized amounts") by examining the average actual Medicare allowable costs per discharge during a base year for hospitals participating in the Medicare program. The standard federal rate is then updated each year for inflation. 42 U.S.C. 1395ww(d)(2)(A) and (B); 49 Fed. Reg. 251 (1984). In making payments to a hospital, the applicable standard rate is adjusted by a "wage index" that accounts for regional variations in labor costs. Finally, the rates reflect an additional weighting factor that takes account of the disparate hospital resources required to treat the wide variety of major and minor illnesses. 42 U.S.C. 1395ww(d)(4). For each of several hundred medical conditions, called diagnosis-related groups (DRGs), the Secretary assigns particular weights by which the

federal rate is to be multiplied. Greater weight is assigned to a DRG that encompasses more complex, costly treatment. The Act requires the Secretary to publish the weights and values to be applied in determining patient reimbursement rates before the start of each fiscal year. 42 U.S.C. 1395ww(d)(6) (Supp. III 1997).

For the years relevant here, the Act also provided, in four statutory clauses, for additional payments to hospitals for "outlier" cases, *i.e.*, those that are extraordinarily costly or involve lengthy periods of hospitalization far in excess of the norm for the type of illness being treated. 42 U.S.C. 1395ww(d)(5)(A)(i)-(iv) (Supp. IV 1986). The first two clauses establish two kinds of outlier payments: day outliers, where a patient's length of stay exceeded the mean length of stay for a particular DRG by a fixed number of days or standard deviations, 42 U.S.C. 1395ww(d)(5)(A)(i) (Supp. IV 1986), and cost outliers, where a hospital's cost-adjusted charges exceeded either a fixed multiple of the applicable DRG prospective payment rate or a fixed dollar amount established by the Secretary, 42 U.S.C. 1395ww(d)(5)(A)(ii) (Supp. IV 1986).[1] The third clause directs that outlier payments "shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable" to the day or cost outlier. 42 U.S.C. 1395ww(d)(5)(A)(iii) (Supp. IV 1986). The fourth clause, at issue here, provides that "[t]he total amount of the additional payments made under this subparagraph for discharges in a fiscal year may not be less than 5 percent nor more than 6 percent of the total payments

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[1] The outlier provisions have been amended to phase out day outlier payments. 42 U.S.C. 1395ww(d)(5)(A)(i) and (v).

projected or estimated to be made based on DRG prospective payment rates for discharges in that year." 42 U.S.C. 1395ww(d)(5)(A)(iv). Finally, the statute requires the Secretary to set outlier thresholds in advance of a fiscal year. 42 U.S.C. 1395ww(d)(6) (Supp. III 1997).

In issuing her final regulation implementing the outlier provisions, the Secretary rejected the suggestion of commenters that the Act contains a "necessary connection between the amount of estimated outlier payments and the actual payments made to hospitals for cases that actually meet the outlier criteria." 49 Fed. Reg. 265 (1984). The Secretary explained that she would "set the outlier criteria so that an estimated six percent of total payments would be made for outliers," and that, "while [she] expect[ed] that under these criteria outlier payments will approximate six percent of total payments, [the Secretary] will pay for any outlier that meets the criteria, even if aggregate outlier payments result in more than six percent of total payments." *Ibid.* Conversely, the Secretary explained that if she "overestimate[d] the amount of outlier payments, [the Secretary] will not adjust the DRG rates to compensate hospitals for funds that were not actually paid for outlier cases." *Id.* at 266.

2. Petitioners are 181 hospitals that brought this action challenging the Secretary's determination concerning the amount of Medicare reimbursement due them for services they provided in fiscal years 1985 and 1986. Petitioners asserted that Section 1395ww(d)(5)(A)(iv) not only instructs the Secretary to set outlier thresholds at the beginning of each fiscal year, but also requires her to adjust outlier payments retroactively if she determines after the end of the fiscal year that aggregate outlier payments do not equal

at least the five-percent statutory target. Petitioners also claimed that the Secretary improperly set the outlier thresholds for fiscal years 1985 and 1986 based on 1981 data that did not reflect reductions in length of hospital stays under the PPS system after it was instituted in 1983. The Provider Reimbursement Review Board authorized petitioners to seek expedited judicial review pursuant to 42 U.S.C. 1395*oo*(f)(1).

3. The district court granted in part and denied in part the parties' cross-motions for summary judgment. Pet. App. 40a-64a. The district court held that Section 1395ww(d)(5)(A)(iv) unambiguously requires the Secretary to adjust outlier payments retroactively if actual payments do not reach the five-percent minimum. The district court, however, rejected petitioners' argument that the Secretary acted in an arbitrary and capricious manner in relying on 1981 data in setting the outlier thresholds for fiscal years 1985 and 1986.

4. The court of appeals reversed. Pet. App. 1a-39a. The court of appeals concluded that the statutory language in Section 13955ww(d)(5)(A)(iv) stating that "[t]he total amount of the additional payments made * * * may not be less than 5 percent" of the total payments "projected or estimated to be made" was ambiguous with respect to whether actual outlier payments must be retroactively adjusted to fall within the statutory targets. *Id.* at 15a-23a. The court of appeals recognized that the language was "certainly capable of accommodating the Hospitals' interpretation * * * of embodying a retrospective inquiry into the amount of outlier payments that *have been* made." *Id.* at 15a. The court of appeals explained, however, that "the phrase 'payments made' * * * can just as easily be read to reflect Congress's intent to 'give directions on actions about to be taken,'" *ibid.*, and therefore the

phrase reflects "a prospective command to the Secretary about how to structure outlier thresholds for payments to be made in advance of each fiscal year," *id.* at 16a (quoting *Regions Hosp.* v. *Shalala*, 522 U.S. 448, 458 (1998)).

The court of appeals further concluded that the Secretary reasonably construed Section 1395ww(d)(5)(A)(iv). Pet. App. 24a-31a. It explained that the Secretary's interpretation implemented Congress's intent in the outlier provision to compensate hospitals only when they experienced aberrational and extraordinary costs. *Id.* at 24a-26a. The court further reasoned that "the Secretary's reading better harmonizes each of the four clauses in paragraph (5)(A)," whereas a contrary interpretation requiring retroactive adjustments could cause the newly computed outlier payments to "not approximate anything close to the marginal cost of care as paragraph (5)(A)(iii) mandates." *Id.* at 26a. Finally, the court of appeals noted that "the Secretary's interpretation avoids the substantial administrative burden attendant with the Hospitals' vision of paragraph (5)(A)(iv)," *id.* at 27a, which would require extensive recalculation of the amount owed to the hospitals, and that the "uncertainty and fluidity in the outlier-payment amounts under the Hospitals' interpretation" was inconsistent with the nature of the PPS system, which "as its name suggests" mandates "prospectively determined reimbursement rates that remain constant during the fiscal year," *id.* at 28a.

Finally, the court of appeals concluded that the Secretary had not provided an adequate explanation for her reliance on 1981 data in calculating the outlier thresholds for the two disputed fiscal years. Pet. App. 31a-38a. The court of appeals accordingly instructed

the district court to remand the case to the Secretary to permit her either to recalculate the outlier thresholds or to offer a reasonable explanation for refusing to use later data in setting the outlier thresholds. *Id.* at 37a-39a.

ARGUMENT

1. Petitioners argue (Pet. 11-14) that this Court should grant certiorari to consider whether 42 U.S.C. 1395ww(d)(5)(A)(iv) clearly requires that actual outlier payments made by the Secretary be not less than five percent (or more than six percent) of projected or estimated DRG payments. The court of appeals' contrary holding, however, does not conflict with any decision of any other court that has construed the statute. In fact, in the only other decision construing the statute, the court upheld the Secretary's construction. *Alvarado Community Hosp.* v. *Shalala*, Nos. 94-0972 et al. (C.D. Cal. May 6, 1996), rev'd on other grounds, 155 F.3d 1115 (1998), amended, 166 F.3d 950 (9th Cir. 1999).

Moreover, the court of appeals correctly concluded (Pet. App. 13a-23a) that nothing in the statutory language bars the Secretary's view that Section 1395ww(d)(5)(A)(iv) prescribes only the methodology to be followed when setting outlier thresholds at the beginning of each fiscal year. Contrary to petitioners' assertion (Pet. 12), the statutory phrase "payments made," when contrasted with the later phrase "payments projected or estimated to be made," does not mean that the earlier phrase unambiguously requires the Secretary to make retroactive adjustment to ensure that actual outlier payments fall within the five to six percent target range. As the court of appeals explained, the phrase "payments made" is "simply an

adjectival phrase," and therefore is temporally ambiguous. Pet. App. 15a (quoting *United States Dep't of the Treasury* v. *FLRA*, 960 F.2d 1068, 1072 (D.C. Cir. 1992)); cf. *Regions Hosp.*, 522 U.S. at 458 (concluding that "the phrase '[amount] recognized as reasonable' might mean costs the Secretary (1) *has* recognized as reasonable * * * or (2) *will* recognize as reasonable").

Furthermore, paragraph (5)(A)(iv) is preceded by paragraph (3)(B), which describes outlier payments as being "estimated by the Secretary." Thus, as the court below noted (Pet. App. 19a), "[g]iven that in paragraph (3)(B) it had already indicated that the Secretary would estimate the amount of outlier payments described in subparagraph (5)(A), Congress could have reasonably concluded that there was no need to provide expressly in paragraph (5)(A)(iv) that the phrase 'payments made' referred to payments estimated to be made."[2]

2. Petitioners also contend (Pet. 14-21) that the Court should grant review to resolve an alleged conflict among the circuits concerning whether a court should defer to an agency's construction of an ambiguous statute when the agency's interpretation is not set forth in a regulation or adjudication. This case, however, is an

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[2] Petitioners also err in relying (Pet. 13-14) on a Senate Report on a recent provision establishing outlier payments for outpatient costs, see Act of Nov. 29, 1999, Pub. L. No. 106-113, App. F, § 201, 113 Stat. 1501A-336 to 1501A-342. This Court has cautioned that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963). In any event, a later Conference Report expressed Congress's intent that the Secretary should make outlier payments for outpatient costs "in a similar way *as is currently done* in the inpatient PPS." H.R. Conf. Rep. No. 479, 106th Cong., 1st Sess. 868 (1999) (emphasis added).

inappropriate vehicle to resolve whatever tension exists in the courts of appeals on that question.

As the court of appeals explained (Pet. App. 23a), "for the past fifteen years, the Secretary has never wavered from [her] interpretation" that Section 1395ww(d)(5)(A)(iv) does not require retroactive adjustments to outlier payments. Indeed, the Secretary set forth her interpretation when she promulgated her final rule, and only after proposing regulations that did not contain any provision for retroactively adjusting outlier payments to ensure that actual payments fell within the statutory range. See 49 Fed. Reg. 265-266 (1984). The Secretary therefore reached her interpretation only after notice and comment rulemaking. In those circumstances, the court of appeals correctly deferred to the Secretary's reasoned judgment under this Court's decision in *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842 (1984). See *Auer* v. *Robbins*, 519 U.S. 452, 462 (1997) (deferring to an agency's interpretation of its regulation reflected in an amicus brief because interpretation is "in no sense a '*post hoc* rationalizatio[n]' advanced by an agency seeking to defend past agency action against attack," and there is "no reason to suspect that the interpretation does not reflect the agency's fair and considered judgment on the matter") (quoting *Bowen* v. *Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988)); see also *Reno* v. *Koray*, 515 U.S. 50, 61 (1995) (deferring to internal agency guidelines); *Shalala* v. *Guernsey Mem'l Hosp.*, 514 U.S. 87, 101-102 (1995) (deferring to agency's interpretive rules in program manual).

Furthermore, petitioners' request that this Court decide when an agency's interpretation of an ambiguous statute warrants deference under *Chevron* is also inconsistent with petitioners' primary contention that

the statute lacks any statutory ambiguity. See Pet. 11 ("The interpretation of [sub]section (d)(5)(A)(iv) should be resolved under step one of the *Chevron* framework."). Thus, were this Court to grant review and accept petitioners' statutory interpretation, this Court would have no occasion to address the second question petitioners present, which is the only question on which they assert that the law lacks clarity.

Finally, petitioners err in suggesting (Pet. 20–21) that the outcome of this case would be affected were a court, instead of applying *Chevron*, to accord the Secretary's view the weight it merited based upon "the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Skidmore* v. *Swift & Co.*, 323 U.S. 134, 140 (1944). As the court of appeals concluded, the Secretary's construction of Section 1395ww(d)(5)(A)(iv) was, in several respects, preferable to petitioners' contrary interpretation. Pet. App. 24a-31a. For instance, "[t]he Secretary's interpretation of paragraph (5)(A)(iv) evinces far greater fidelity to Congress's conception of outlier payments than does the view espoused by the Hospitals," because "if it turns out that actual outlier payments do not meet the five-percent target at the end of the fiscal year, it is because the lengths of stay for DRGs in that year proved to be shorter than the historical averages reflected in the data on which the Secretary based her threshold calculations." *Id.* at 24a. By contrast, under petitioners' interpretation, hospitals would be "guaranteed a substantial and fixed sum of outlier payments," "regardless of actual costs or inpatient lengths of stay during a fiscal year," *ibid*, even though it is "unlikely that Congress * * * wanted

hospitals to reap additional compensation over and above the standard DRG payment where treatment costs for a particular discharge were not extraordinarily costly relative to the mean costs for that DRG," *id.* at 25a-26a.

Similarly, as the court of appeals explained, "[i]t strains credulity to assume that Congress would have directed the Secretary to establish outlier thresholds in advance of each fiscal year, *see* § 1395ww(d)(3)(B), (d)(6), and process millions of bills based on those figures, only to have her at the end of the year recalibrate those calculations, reevaluate anew each of the millions of inpatient discharges under the revised figures, and disburse a second round of payments." Pet. App. 27a-28a. By contrast, the Secretary's construction "promotes certainty and predictability of payment for not only hospitals but the federal government—concerns that played a prominent role in Congress's decision to adopt PPS." *Id.* at 28a-29a; see also *id.* at 30a-31a ("A less determinate policy would not only deprive hospitals of the ability to make accurate projections about outlier payments for the forthcoming year but also threaten them at the end of each year with the prospect of actually having to forfeit a portion of those payments to the Secretary * * * [if] outlier payments * * * exceeded six percent of estimated DRG-related payments.").

3. This case also does not warrant this Court's review because additional proceedings on remand may obviate the need for further consideration of the statutory construction issue. The court of appeals instructed the district court to remand the action to the Secretary to permit her to provide an adequate explanation for her choice of data in calculating the outlier thresholds for the two disputed fiscal years. Pet. App. 37a-39a.

Petitioners of course may challenge any final action made on remand by the Secretary, and a successful challenge might ultimately require the Secretary to provide additional compensation to petitioners that would obviate the need to address the issue of statutory construction presented here.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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APRIL 2000